

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. 18574

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland</b>	
c. LENGTH OF STAY IN 1b <b>15 days</b>		d. STREET ADDRESS <b>123 Roberts St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Frances</b>	Middle <b>Rose</b>	Last <b>Abe</b>
4. DATE OF DEATH	Month <b>August</b>	Day <b>5</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 29, 1884</b>
8. AGE (In years lost birthday) <b>74 yrs.</b>		9. IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alonzo Ogden</b>	
14. MOTHER'S MAIDEN NAME <b>Ida Skinner</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Evelyn Cavey</b>	
		Address <b>123 Roberts St., Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b>			
DUE TO <b>592X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Nephritis with Uremia</b>		?	
DUE TO (c) <b>Hypertension</b>		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocardial Fibrosis, Aortitis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)      (State)	
21. I certify that I attended the deceased from <b>July 21, 1958</b> , to <b>August 5, 1958</b> that I last saw the deceased alive on <b>August 5, 1958</b> , and that death occurred at <b>11:20 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel M. Jacobson</i>		ADDRESS (Street, city or town, state) <b>50 Pershing Street, Cumberland, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Samuel M. Jacobson, M.D.</b>		DATE SIGNED <b>6/6/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/8/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Abe Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Ridgeley, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 11 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Al. Leach</i>	

## CERTIFICATE OF DEATH

NAME	AGE	SEX	DEATH DATE	TIME	CAUSE
EDWARD J. MURRAY	50	M	APRIL 22, 1910	10:30 A.M.	HEART DISEASE
DIED AT HOME					
IN THE PRESENCE OF					
WITNESSED BY					
RECORDED AND FILED					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08572

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8575

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>50 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>211 N. Mechanic Street</b>		e. STREET ADDRESS <b>211 N. Mechanic St.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>RUE HERBERT ALLEN</b>		First	Middle	Lost	4. DATE OF DEATH <b>Aug. 7,</b>	Month	Doy	Year <b>19 58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1889</b>	9. AGE (In years last birthday) <b>69 yrs.</b>	10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <input type="checkbox"/> WW 1		16. SOCIAL SECURITY NO. <b>214 05 4956</b>		17. INFORMANT <b>Louis W. Allen</b>		Address <b>Cumberland, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b> (a), stating the underlying cause last. (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Aug. 7, 1958</b>				
EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/9/1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 11 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Alfred Leach</i>		

MEDICAL - A NUMBER OF CERTIFICATES OF EACH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

8573

Reg. Dist. No.

8659			
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		c. LENGTH OF STAY IN 1b <b>33 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Barton</b>	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma</b>		First <b>Roberta</b>	Middle <b>Ashby</b>
4. DATE OF DEATH Month <b>Aug</b>	Month <b>Day</b>	Day <b>Year</b>	Year <b>6 19 58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 19, 1879</b>
9. AGE (In years last birthday) <b>78 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry Dawson</b>	14. MOTHER'S MAIDEN NAME <b>Eliza Major</b>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Curtiss Griffith-Barton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>8 Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 10, 1958</b> , to <b>Aug 6, 1958</b> , that I last saw the deceased alive on <b>Aug 6, 1958</b> , and that death occurred at <b>115 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul R. Wilson</b>	ADDRESS (Street, city or town, state) <b>M.D. 115 Ashfield St. Pitcairn, W. Va.</b>		
PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>	DATE SIGNED <b>8-8-58</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/9/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Meadow Point</b>	22d. LOCATION (City, town, or county) (State) <b>Keyser</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. B. Wal</b>	ADDRESS <b>Westernport, Md.</b>	24a. REC'D. BY REGISTRAR <b>Aug 12 1958</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. Tracy</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8576

## CERTIFICATE OF DEATH

08574

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
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1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>21 DAYS</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		
f. STREET ADDRESS <b>18 GRANT STREET</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>H.</b>	Last <b>BOLDEN</b>	
4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>29</b>	Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>DECEMBER 10</b>	
8. AGE (In years lost birthday) <b>76 yrs.</b>	9. IF UNDER 1 YEAR Months <b>0</b>	10. IF UNDER 24 HRS. Days <b>0</b>	11. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machine Operator</b>		
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>CHARLES L. BOLDEN</b>		14. MOTHER'S MAIDEN NAME <b>CHRISTINE DEGELTREE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-3073</b>		
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b> DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONS AND DEATH <b>about 3 years.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>8-29-58</b>
20f. (City or town) <b>8-29-58</b>		(County)		(State)
21. I certify that I attended the deceased from <b>5-17-58</b> to <b>8-29-58</b> , that I last saw the deceased alive on <b>8-22-58</b> , and that death occurred at <b>4:15 AM</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Howard N. Tolson</b>		ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>		DATE SIGNED <b>8-29-58</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Frostburg Memorial Park, Frostburg</b>
22d. LOCATION (City, town, or county) <b>Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernie H. Montague</b>		24a. REC'D BY REGISTRAR <b>Hafer Funeral Home</b>
				24b. REGISTRAR'S SIGNATURE <b>Arline S. Tolson</b>
				DATE <b>SEP 4 '58</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G233 9-2-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

08575

8577

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>27 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BARTON</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. STREET ADDRESS <b>ROUTE #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CATHERINE H. BROADWATER</b>		First	Middle	Last	4. DATE OF DEATH <b>FEBRUARY 6, 1958</b>	Month <b>AUGUST</b>	Day <b>21</b>	Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>FEBRUARY 6, 1972</b>	9. AGE (In years lost birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR <b>Months</b>	IF UNDER 24 HRS. <b>Days</b>	Hours <b>Hours</b>	Min. <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>LEVI BITTINGER</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA BROADWATER</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> DUE TO <b>General arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes mellitus</b> DUE TO <b>General arteriosclerosis</b> <b>3 years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Diagnosed left foot - Diabetes mellitus</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> - p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>59 Street St</b>		(County)	(State)
21. I certify that I attended the deceased from <b>July 24, 1958</b> , to <b>Aug 1, 1958</b> , that I last saw the deceased alive on <b>Aug 1, 1958</b> , 19 <b>58</b> , and that death occurred at <b>11:25 PM</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>S. Weisman</b>		ADDRESS (Street, city or town, state) <b>59 Street St, Cumberland, Md.</b>							
DATE SIGNED <b>8/2/58</b>									
PHYSICIAN'S NAME (Type) <b>DR. S. WEISMAN</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/24/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. View</b>		22d. LOCATION (City, town, or county) <b>MOSCOW</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. B. Weisman</b>		ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANUFACTURED BY THE STATE DEPARTMENT OF HEALTH - CALIFORNIA

CERTIFICATE OF DEATH

DEATH CERTIFICATE

REGISTRATION NO.

EXPIRATION DATE

ISSUED TO

EXPIRED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08576

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		c. LENGTH OF STAY IN 1b <b>15 HOURS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		3 VOL-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>				d. STREET ADDRESS <b>1323 W. 42nd Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>RACHEL</b>	Middle <b>C</b>	Last <b>BROWN</b>	4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>9</b>	Year <b>1958.</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>JANUARY 13 1879</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Carroll Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>ISAAC STONESIFER</b>		14. MOTHER'S MAIDEN NAME <b>Martha LIPPEY</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Myocarditis</b>		(c)		2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> at work <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 4, 1958</b> to <b>Aug 9, 1958</b> , that I last saw the deceased alive on <b>Aug 9, 1958</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Cumberland Md Aug 11 1958</b>					
ACTUAL SIGNATURE <b>Clay E. Durrett</b>		DATE SIGNED <b>Aug 11 1958</b>					
PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-13-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli Cumberland, Md.</b>		ADDRESS <b>James F. Scarpelli</b>					
		24a. REC'D BY REGISTRAR <b>AUG 12 1958 Arthur J. Rooney</b>					
		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Rooney</b>					

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08577

8650

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>60 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>234 E. Main</b>		d. STREET ADDRESS <b>234 E. Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Alexander</b>		First <b>Alexander</b>	Middle <b>Close</b>	Lost	4. DATE OF DEATH Month <b>8</b>	Day <b>16</b>	Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-1881</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	Days <b>0</b>	11. IF UNDFT 24 HRS. Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>		11. BIRTHPLACE (State or foreign country) <b>Eckhart, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James Close</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Dudley</b>			Address <b>Frostburg, Md.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>213-05-7118</b>		17. INFORMANT <b>Mrs. Alexander Close, 234 E. Main,</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Aug 2, 1958</b> to <b>Aug 16, 1958</b> , that I last saw the deceased alive on <b>Aug 13, 1958</b> , and that death occurred at <b>10:44 A.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>WOMC Lane</b>		ADDRESS (Street, city or town, state) <b>Frostburg, MD.</b>						
PHYSICIAN'S NAME (Type) <b>WOMC Lane</b>		DATE SIGNED <b>Aug 16, 1958</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-18-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Frostburg, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burk H. Monteeen</b>		ADDRESS <b>Hafer Funeral Home 23 E. Main, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>Pat Aug 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

STATE DEPARTMENT OF LABOR - BUREAU OF LABOR STATISTICS

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08578

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>Thomas</b>	Middle <b>Joseph</b>	Last <b>Condry</b>	4. DATE OF DEATH 8 2 1958	Month 8	Day 2	Year 1958
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-1904</b>	9. AGE (In years lost birthday) <b>54 yrs.</b>	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kelley Tire Co., Eckhart, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Eckhart, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13. FATHER'S NAME <b>William Condry</b>				14. MOTHER'S MAIDEN NAME <b>Mollie Hershberger</b>		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>214-01-3726 Mrs. T. Jos. Condry, Eckhart, Md. (Wife)</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>705.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>Lupus erythematosus</i>				INTERVAL BETWEEN ONSET AND DEATH <b>3-4 years,</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frostburg</b>	(County) <b>Washington</b>	
21. I certify that I attended the deceased from _____		6-1, 1958, to 8-2, 1958		that I last saw the deceased alive on 8-2, 1958, and that death occurred at 10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>39 W. Main St Frostburg, Md.</b>		
ACTUAL SIGNATURE <b>H.C. Diehl</b>		M.D.				DATE SIGNED <b>8/4/58</b>		
PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>								
22o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-6-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Eckhart Cemetery</b>		22d. LOCATION (City, town, or county) <b>Eckhart</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Hartung</b>		ADDRESS <b>Hafer Funeral Home Frostburg, Md.</b>				(State) <b>Md.</b>		
				24a. REC'D BY REGISTRAR DATE <b>AUG 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albert Deuch</b>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08579

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8579		00	
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>75 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>516 Maryland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BERTHA</b>		First <b>COPELAND</b>	Middle <b>COPELAND</b>
4. DATE OF DEATH <b>Aug. 6, 1958</b>		Month <b>Aug.</b>	Doy <b>6</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 16, 1872</b>	
9. AGE (in years last birthday) <b>86 yrs.</b>		10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Abbie Copeland</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diffuse carcinomatosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
17a x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>DUE TO</b>		(b) <b>Carcinoma of breast</b> <b>DUE TO</b>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Aug. 6, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/9/1958</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Aut. - J. Kight</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

U8580

## CERTIFICATE OF DEATH

Reg. Dist. No.

8580							
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>		d. STREET ADDRESS <b>1531 Cumberland St.,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>531 Cumberland, St.,</b>				d. STREET ADDRESS <b>1531 Cumberland St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Marietta</b>	Middle <b></b>	Last <b>Coulehan</b>	4. DATE OF DEATH	Month <b>August</b>	Day <b>5</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 13, 1871</b>	9. AGE (In years lost birthday) yrs. <b>87</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Buffalo, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Banks</b>		14. MOTHER'S MAIDEN NAME <b>Mary Argus</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Joseph M. Couleham</b>		Address <b>Woodlawn, La Vale, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b>		DUE TO <b>Chronic Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>169 Green St Cumberland Md 21558</b>					
ACTUAL SIGNATURE <b>James T. Johnson Jr. M. D.</b>		DATE SIGNED <b>169 Green St Cumberland Md 21558</b>					
PHYSICIAN'S NAME (Type) <b>James T. Johnson Jr. M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/8/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>S. S. Peter &amp; Paul's</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08581

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>b2 CUMBERLAND</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.</b>		d. STREET ADDRESS <b>19 MARION STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>LLOYD</b>	Middle <b>EDGAR</b>	Last <b>DEAHL</b>	4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>18</b>	Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 30 1907</b>	9. AGE (In years last birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman-B &amp;O Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>JOHN DEAHL</b>		14. MOTHER'S MAIDEN NAME <b>BERTHA LININGER</b>		Address <b>CUMBERLAND, MD.</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-0953</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Vascular Accident</b> <b>Hypertension Andisvascular Disease</b> <b>Arteriosclerosis Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>31 hrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy.	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)
21. I certify that I attended the deceased from <b>Aug.</b> , 19 <b>58</b> , to <b>Aug.</b> , 19 <b>58</b> that I last saw the deceased alive on <b>Aug. 12 1958</b> , and that death occurred at <b>7:00A M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Dr. O. G. Himmelwright</i>	ADDRESS (Street, city or town, state) <b>133 Va Ave, Cumberland, Md.</b>							DATE SIGNED <b>8/15/58</b>
PHYSICIAN'S NAME (Type) <b>XDR. O. G. HIMMELWRIGHT</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/20/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8582

## CERTIFICATE OF DEATH

08582

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/25/54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Julia	Middle May	4. DATE OF DEATH August 17, 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Westernport, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Nelson Derham		14. MOTHER'S MAIDEN NAME Mary Catherine Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT P.O. Box 599 Address Cumberland, Md.	
		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592 X DUE TO Chronic Myocarditis INTERVAL BETWEEN ONSET AND DEATH ?			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cerebral arteriosclerosis ?			
(c) DUE TO Chronic nephritis ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Paralysis agitans.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/25/54, 19, to 8/17/58, 19, that I last saw the deceased alive on 8/16/58, 19, and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 8/18/58	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/58	
22c. NAME OF CEMETERY OR CREMATORIAL Philos		22d. LOCATION (City, town, or county) Westport	
23. FUNERAL DIRECTOR'S SIGNATURE El. Boal		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR AUG 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18583

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.</b>		d. STREET ADDRESS <b>30 ROBERTS St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>PEARL</b>	Middle <b>E.</b>	Last <b>DIVELBLISS</b>	4. DATE OF DEATH <b>AUGUST 20, 1958</b>	Month <b>AUGUST</b>	Day <b>18</b>	Year <b>1958</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 20, 1919</b>	9. AGE (In years lost birthday) <b>38 yrs.</b>	IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES RICE</b>		14. MOTHER'S MAIDEN NAME <b>SARAH JOHNSON</b>		Address <b>CUMBERLAND, MD.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>353.2</b> States <b>Epileptics</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>58</b> , to <b>Aug</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Aug 17, 1958</b> , and that death occurred at <b>4:23A M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>8/18/58</b>	
ACTUAL SIGNATURE <b>DR. O. G. HIMMELRIGHT</b>		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug 26, 1958 Davis Mem. Park.</b>		22b. DATE THEREOF <b>Aug 26, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Davis Mem. Park.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb. MD</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>REC'D 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Robert L. Knott</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director,  
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08584

8584

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WEST VIRGINIA</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GORMANIA</b>		d. STREET ADDRESS <b>85x-3</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVES.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>F</b> <b>FRANCES</b>	Middle <b>V.</b>	DULING <b>MMXXIX</b>	4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>11</b>	Year <b>1958</b>
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 27, 1886</b>	9. AGE (In years lost birthday) <b>71</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY: <b>U. S. A.</b>		
13. FATHER'S NAME <b>D. F. KERLIN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA BOWMAN</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MARYLAND</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Hypertensive arterio-sclerotic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) <b>Cardio vascular disease (benign)</b> DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bayard</b>	(County) <b>W. Va.</b>	(State) <b>W. Va.</b>
21. I certify that I attended the deceased from <b>8:8</b> to <b>8:11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8-11-58</b> , and that death occurred at <b>5:45P</b> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Wm. F. Williams M.D.</b>							ADDRESS (Street, city or town, state) <b>Bayard W. Va.</b>	
PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>							DATE SIGNED <b>8-12-58</b>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial Aug 14 58</b>		22b. BURIAL, Crematory <b>Bayard Cemetery</b>		22c. LOCATION (City, town or county) <b>Bayard W. Va.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Heights Oakland Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>AUG 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SI BROWNTREE - ATTACH TO THE MISSOURI STATE QUARTER

ATTACH TO STATIONED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 08/01/2018 BY SP2 JASPER HARRIS

EXPIRE DATE 08/01/2019 BY SP2 JASPER HARRIS

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EXPIRE DATE 08/01/2019 BY SP2 JASPER HARRIS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8585

## CERTIFICATE OF DEATH

08585

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>2/15/1873</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. STREET ADDRESS <b>406 Baltimore Avenue</b>	
f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sarah</b>		First <b>B.</b>	Middle <b>Eyler</b>
4. DATE OF DEATH <b>August 27, 1958</b>	Month <b>August</b>	Day <b>27</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/15/1873</b>
9. AGE (In years lost birthday) <b>85 yrs.</b>	10. IF UNDER 1 YEAR Months <b>85</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Chambersburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Addison H. Eyler</b>		14. MOTHER'S MAIDEN NAME <b>Sarah B. Wolfe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O. Box 599 Allegany County Infirmary Records</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592x</b> DUE TO <b>Chronic myocardial degeneration</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO <b>Chronic nephritis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Smoking</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/10/58</b> , 19, to <b>8/27/58</b> , 19, that I last saw the deceased alive on <b>8/27/58</b> , 19, and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b>		ADDRESS (Street, city or town, state) <b>49 Greene St. Cumberland, Md.</b>	
DATE SIGNED <b>8/28/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/30/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Zion Mems. Park</b>
22d. LOCATION (City, town, or county) <b>Cumb. Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 2 1958</b>	24b. REGISTRAR'S SIGNATURE <b>John S. Mann</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA - DEPARTMENT OF CHANCERY

CERTIFICATE OF DEATH

CEMETERY

DEATH

REGISTRATION

SEARCH

INDEX

1  
X  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08586

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. AT 5ME  
5M 2/57

8586

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas W</b>		First <b>Thomas</b>	Middle <b>Fahey</b>
4. DATE OF DEATH <b>August 14</b>		Month <b>August</b>	Doy <b>14</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Oct. 4, 1875</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thomas W. Fahey</b>	
14. MOTHER'S MAIDEN NAME <b>Bridget McGinnis</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>705-09-9975</b>		17. INFORMANT Address <b>Richard E. Fahey, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemothorax, right</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
DUE TO <b>825 X</b> Conditions, if any, which gave rise to immediate cause (b) <b>Crushed chest</b>		6 days	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident</b>			
20c. TIME OF INJURY Month, Day, Year <b>6:00 p.m. Aug. 6 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Route 28 near Ridgeley, W. Va.</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Near Ridgeley</b>
20f. (City or town) <b>Mineral</b>		(County) <b>W. Va.</b> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED <b>August 14, 1958</b>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22c. DATE THEREOF <b>8-18-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 18 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haas</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08587

Reg. Dist. No.

1		8651		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.		o. COUNTY Allegany		o. STATE Maryland	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		c. LENGTH OF STAY IN 1b RURAL and give nearest town) Frostburg		b. COUNTY Allegany	
		14 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		d. STREET ADDRESS 73 W. Main Street	
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Isabelle		First	Middle	Lost	4. DATE OF DEATH August 18th, 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 21st, 1870	9. AGE (In years lost birthday) 87 yrs.
		WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own housework		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME James Findlay		14. MOTHER'S MAIDEN NAME Rose Ann Read		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Anna Shea, 73 W. Main St., F' bg., Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X		Cerebral Hemorrhage.		14 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO		—	
		(b) Hypertension Cardio -		—	
		DUE TO		—	
		(c) Vascular disease.		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-15, 1954 to 8-18, 1958, that I last saw the deceased alive on 8-18, 1958, and that death occurred at 1:55 PM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		H. C. Dietl, M.D.		DATE SIGNED 8/18/58	
PHYSICIAN'S NAME (Type)		H. C. Dietl, M.D.		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-20-58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	
				22d. LOCATION (City, town, or county) Altoona	
				(State) Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE AUG 21 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

WISCONSIN STATE DOCUMENTS JOURNAL, 16

CERTIFICATE OF DATA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18588

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8587

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>53 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. STREET ADDRESS <b>126 Columbia St.</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLOTTE</b>		First <b>B.</b>	Middle <b>GARDNER</b>
4. DATE OF DEATH <b>Aug. 18</b>	Month <b>18</b>	Doy <b>19</b>	Year <b>58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	b. DATE OF BIRTH <b>Sept. 26, 1871</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Marbourg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>James Gardner</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>904.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Vascular Disease</b> DUE TO (c) <b>Fractured left hip</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 Mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.) <b>Fell and fractured hip at home</b>			
20c. TIME OF INJURY Month, Day, Year <b>July 5 1958</b>		20d. INJURY OCCURRED Hour White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Cumberland, Alleg. Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>August 18, 1958</b>
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 20, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>AUG 20 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08588

## 8588 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MM MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>711 MONTGOMERY AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>MYRTLE M.</b>		First	Middle	Last	4. DATE OF DEATH <b>GARRETT</b>	Month <b>AUGUST</b>	Day <b>25</b>	Year <b>19 58</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>APRIL 8 1889</b>	9. AGE (In years lost birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND-Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>JOHN HECK</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH LOGUE</b>		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-32-8210</b>		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Warrene Central Neomorbridge</b> <b>33IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Hypertension</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug. 24, 19 58</b> to <b>Aug 25, 19 58</b> , that I last saw the deceased alive on <b>Aug. 24, 19 58</b> , and that death occurred at <b>2:50A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>					DATE SIGNED <b>8/26/58</b>			
ACTUAL SIGNATURE <b>Clay B. Durrett</b>		PHYSICIAN'S NAME (Type) <b>DR. CLAY DURRETT</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 27, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8589

## CERTIFICATE OF DEATH

08590

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>17 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Rose</b>	Middle <b>Gerdeman</b>	4. DATE OF DEATH <b>August 8, 1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/2/1882</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>England</b>	
10c. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
13. FATHER'S NAME <b>Henry Cavanaugh</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Pt's Chart.</b>	
17. INFORMANT <b>Henry G. Gerdeman</b>		Address <b>Ambulance 541 Henderson Ave. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>587.1</b>		<b>acute pancreatitis</b> 1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>chronic pancreatitis</b>		6 months	
DUE TO <b>acute pancreatitis</b>			
(c) <b>chronic pancreatitis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-7-</b> , 19 <b>58</b> , to <b>8-8-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8-7-</b> , 19 <b>58</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Green St., Cumberland, Md.</b>		DATE SIGNED	
ACTUAL SIGNATURE <b>L. Brins</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug 11, 1958</b>		22b. DATE THEREOF <b>Aug 11, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Patrick's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Stein, Inc. Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 11 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08591

8652

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>49 Linden St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA</b>		First <b>MARGARET</b>	Middle <b>GLORIOUS</b>
4. DATE OF DEATH <b>August 5, 1958</b>	Month <b>Aug</b>	Dy <b>5</b>	Year <b>58</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-13-1928</b>
9. AGE (In years lost birthday) <b>30 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>invalid</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>William Glorious</b>	
14. MOTHER'S MAIDEN NAME <b>Josephine Dailey</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Wm. Glorious, Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Sarcoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<b>Sarcoma rt shoulder</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
20c. TIME OF INJURY Month, Doy, Year Hour o. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>11/11/1956</b> to <b>8/15/1958</b> that I last saw the deceased alive on <b>8/14/1958</b> , and that death occurred at <b>11/11/1958</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Broadway, Frostburg, Md.</b>			
ACTUAL SIGNATURE <b>Hilda J. Walters, M.D.</b>		DATE SIGNED <b>8/17/58</b>	
PHYSICIAN'S NAME (Type) <b>Hilda J. Walters, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 8 '58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Michaels Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 11 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Asst. Secy.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached from the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - GOVERNMENT OF HAITI - PORT-AU-PRINCE

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
ADDRESS	DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH
CERTIFICATION			
SIGNED AND DATED			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08592

8590

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>39 N. WATER ST.</b>				
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b>		First	Middle	Last	4. DATE OF DEATH <b>GRECO</b>	Month <b>AUGUST</b>	Day <b>3,</b>	Year <b>1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>SEP. 12, 1875</b>	9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>ITALY</b>		
13. FATHER'S NAME <b>FRANK GRECO</b>				14. MOTHER'S MAIDEN NAME <b>MATHILDA OTT</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		<b>214-01-3581</b>		Frank Greco, 39 N. Water St., F' bg., Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <i>Arteriosclerotic vascular dis. (coronary)</i> INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Sequelae of arteritis left knee</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>8-18-1958</b> to <b>8-3-1958</b> that I last saw the deceased alive on <b>8-2-1958</b> , and that death occurred at <b>10:40 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>W. J. Williams M.D.</b> ADDRESS (Street, city or town, state) <b>Frostburg, Md.</b> DATE SIGNED <b>8-4-58</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-6-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Michael's Cemetery, Frostburg, Md.</b>		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Duff</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albermarle</b>		

DEPARTMENT OF STATE OF MARYLAND - BALTIMORE, MD  
CERTIFICATE OF DEATH

RECEIVED  
MAY 10 1910  
BALTIMORE CITY CLERK'S OFFICE

RECEIVED  
MAY 10 1910  
BALTIMORE CITY CLERK'S OFFICE

RECEIVED MAY 10 1910  
BALTIMORE CITY CLERK'S OFFICE

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8591 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>427 Henderson Avenue</b>		d. STREET ADDRESS <b>427 Henderson Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>KATHERINE</b>		First	Middle	Lost	4. DATE OF DEATH <b>August 4</b>	Month	Day	Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1875</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Andrew II. Heller</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Heyer</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Chas. Grimes, 108 Oak St., Cumberland, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (o) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Coronary occlusion</b> <b>Coronary Sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									DATE SIGNED
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 5, 1958	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>		M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 7, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>AUG 11 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Alt. Hafer</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME  
SM 2/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08594

8592

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>WEST VIRGINIA</b>		b. COUNTY <b>HAMPSHIRE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4HR. 5 MIN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROMNEY</b>		d. STREET ADDRESS <b>85X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>KATE</b>	Middle <b>M.</b>	Lost	4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>30</b>	Year <b>1958</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>DECEMBER 27</b>	9. AGE (In years lost birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
8. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN D. MILLAR</b>		14. MOTHER'S MAIDEN NAME <b>NANCY SHEETZ</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>WARWICK &amp; MEMORIAL AVE. MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Terminal Cardiac failure		INTERVAL BETWEEN ONSET AND DEATH <b>+8 hours</b>			
(b)		DUE TO		Hypertensive Cardiovascular disease ?					
(c)		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from <b>29 Aug. 1958</b> , to <b>30 Aug. 1958</b> , that I last saw the deceased alive on <b>29 Aug. 1958</b> , and that death occurred at <b>3:15 AM</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>W. Alfred Van Ormer M.D. 172 S. Centre St. 20 Aug. 58</b>									
DATE SIGNED <b>20 Aug. 58</b>									
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)		<b>DR. W. A. VAN ORMER</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 1, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Indian Mound</b>		22d. LOCATION (City, town, or county) <b>Romney</b>		(State) <b>W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Reich Sheffer</b>		ADDRESS <b>Romney W. Va.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 8 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08595

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7/25/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle B. Lost Harris		4. DATE OF DEATH August 4, 1958	
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/18/1874		9. AGE (In years lost birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Harris		14. MOTHER'S MAIDEN NAME Margaret Beverige	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 DUE TO <i>Pulmonary Hypostasis</i> INTERVAL BETWEEN ONSET AND DEATH 18 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Hypocarditis</i> ? (c) <i>General arteriosclerosis</i> ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/25/58, 19, to 8/4/58, 19, that I last saw the deceased alive on 8/2/58, 19, and that death occurred at 3:55A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. McLean</i>		ADDRESS (Street, city or town, state) M.D. - 49 Greene St. DATE SIGNED 8/4/58	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM West Newton Cemetery		22d. LOCATION (City, town, or county) (State) West Newton, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	
		24a. REC'D BY REGISTRAR DATE AUG 11 '58	
		24b. REGISTRAR'S SIGNATURE <i>Alt. Haferich</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## Dr. Murrett

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08596

		8594 CERTIFICATE OF DEATH		Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>		b. COUNTY <b>Allegany</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Race Street</b>		d. STREET ADDRESS <b>11 Race Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Cecelia A. Hart</b>		First	Middle	4. DATE OF DEATH Month Day Year <b>August 25 1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>May 13, 1883</b>	9. AGE (In years last birthday) <b>75 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Peter F. Hart</b>		14. MOTHER'S MAIDEN NAME <b>Eva Nies</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Paul Yarnall, 11 Race St. Cumberland, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Coronary Thrombosis Death</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<b>Myocarditis &amp; Decompensation 4 yrs</b>		
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug. 1955</b> , 19 <b>55</b> , to <b>Aug. 25, 1958</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Aug. 1, 1955</b> , 19 <b>55</b> , and that death occurred at <b>7:40 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>Aug. 29, 1958</b>		
ACTUAL SIGNATURE <b>Cecelia Murrett</b>	22. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>Aug. 28, 1958</b> 22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Peters &amp; Pauls Cem.</b> 22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>AUG 29 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>

STATE OF NEW YORK - DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08597

8595

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>5 Weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crump Nursing Home, 761 Fayette St.</b>		e. STREET ADDRESS <b>134 Seymour Street</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES L HEINRICH</b>		First	Middle
4. DATE OF DEATH <b>August 3, 1958</b>		Month	Day
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>July 19, 1869</b>		9. AGE (In years last birthday) <b>89 yrs.</b>	10. IF UNDER 1 YEAR Months Days
11. BIRTHPLACE (State or foreign country) <b>Oldtown, Maryland</b>		12. IF UNDER 24 HRS. Hours Min.	13. CITIZEN OF WHAT COUNTRY? <b>USA</b>
14. MOTHER'S MAIDEN NAME <b>Margaret Schilling</b>		15. FATHER'S NAME <b>John Henry Heinrich</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Donald Heinrich</b>	
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		19. ADDRESS <b>410 Pulaski Street Cumberland, Maryland</b>	
20. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		24. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.		28. ADDRESS (Street, city or town, state) <b>Cumberland, Maryland</b>	
29. ACTUAL SIGNATURE <b>Clay E. Durett M.D.</b>		30. DATE SIGNED <b>Aug. 6, 1958</b>	
31. PHYSICIAN'S NAME (Type) <b>Clay E. Durett M.D. 236 Va. Ave., Cumberland, Maryland</b>			
32. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		33. DATE THEREOF <b>Aug. 6, 1958</b>	
34. NAME OF CEMETERY OR CREMATORIAL <b>Hillcrest Burial Park</b>		35. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
36. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		37. ADDRESS <b>John J. Hafer, Cumberland, Maryland</b>	
38. REC'D BY REGISTRAR <b>AUG 11 '58</b>		39. REGISTRAR'S SIGNATURE <b>Abraham</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8596

## CERTIFICATE OF DEATH

108598

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>8/8/53</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Edna</b>	Middle <b>M.</b>	Last <b>Hice</b>
4. DATE OF DEATH	Month <b>August</b>	Day <b>13,</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/21/1883</b>
9. AGE (In years, last birthday) <b>74</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland, Mt. Savage</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Charles R. Uhl</b>		14. MOTHER'S MAIDEN NAME <b>Alice Holtzman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT P.O. Box 599 <b>Allegany County Infirmary Records</b>	Address <b>Cumberland, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Pulmonary Hypostasis. 48 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO Chronic Myocarditis?			
DUE TO Senile Arteriosclerosis?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile psychosis.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/8/53</b> , 19, to <b>8/13/58</b> , 19, that I last saw the deceased alive on <b>8/13/58</b> , 19, and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. McLean</i>		ADDRESS (Street, city or town, state) <b>49 Green St.</b> DATE SIGNED <b>8/14/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/16/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Savage Meth. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>AUG 19 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

BY THE STATE OF TEXAS - LAWMAKERS  
THE STATE OF TEXAS - LAWMAKERS

CERTIFICATE OF PAPER

TEXAS

BY THE STATE OF TEXAS - LAWMAKERS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08599

8597

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
3. NAME OF DECEASED (Type or print) <b>Frank P.</b>		d. STREET ADDRESS <b>204 E. Laing Ave.,</b>	
First <b>Frank</b>		Middle <b>P.</b>	Last <b>Horwath</b>
4. DATE OF DEATH <b>August 16 1958</b>		Month <b>August</b>	Day <b>16</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>4/6/88</b>		9. AGE (In years lost birthday) <b>70 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Window Washer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11. BIRTHPLACE (State or foreign country) <b>Poland</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Michael Horwath</b>	
14. MOTHER'S MAIDEN NAME <b>Machalino Blakawski</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>217-10-1425</b>		17. INFORMANT <b>Patient's Chart.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO  (c) DUE TO  (d) DUE TO		<b>Carcinoma of Stomach</b> <b>Carcinomatosis</b> <b>3 mon</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 20, 1958</b> to <b>Aug. 16, 1958</b> , that I last saw the deceased alive on <b>Aug. 15, 1958</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Clay Durrett M.D.</b> <b>Cumberland, Md.</b> <b>DATE SIGNED</b> <b>8/16/58</b>	
ACTUAL SIGNATURE <b>Clay Durrett</b>		PHYSICIAN'S NAME (Type) <b>Dr. Clay Durrett</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-19-1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Cemetery</b>
22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 19 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08690

Reg. Dist. No.

8598

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN lb Rt. # 6 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		d. STREET ADDRESS Locust Grove	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Wesley Huff		First	Middle
4. DATE OF DEATH August 6 1958	Last	Month	Doy
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1897
9. AGE (In years last birthday) 61 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintainance work,	10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	11. BIRTHPLACE (State or foreign country) Rawlings, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Leonard W. Huff		
14. MOTHER'S MAIDEN NAME Mary Susan Baker	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, 16. SOCIAL SECURITY NO. 217-10-4504		
17. INFORMANT Mrs. Beulah I. Huff Rt. # 6 Cumberland, Md.	Address ( wife )		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 802 X		INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Loss of blood, severe trauma		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran over by Railroad Locomotive	
20c. TIME OF INJURY Month, Day, Year Hour: Min: Sec: Aug. 5, 1958 8:30 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Railroad Track Locust Grove. Alleg. Md.	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DATE SIGNED August 6, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.		24a. REC'D BY REGISTRAR DATE AUG 11 '58	
		24b. REGISTRAR'S SIGNATURE Debra Smith	



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08601

8599

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and can be easily filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>141 Reynolds Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Emma T. Humphreys</b>		First	Middle	Last	4. DATE OF DEATH <b>August 27 1958</b>	Month	Day	Year
5. SEX <b>F</b>		6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2/26/1873</b>	9. AGE (In years lost birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Jospeh Stevens</b>		14. MOTHER'S MAIDEN NAME <b>Francis Garner</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Chart</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition, extreme</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 Months</b>		
17/x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the Cervix, Grade IV</b>						10 Months		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Algonquin Hotel, Cumberland, Md.</b>		(County) (State)
21. I certify that I attended the deceased from <b>August 20th, 1958</b> , to <b>August 27th, 1958</b> , that I last saw the deceased alive on <b>August 26th, 1958</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Algonquin Hotel, Cumberland, Md.</b>		DATE SIGNED <b>8-27-58</b>
ACTUAL SIGNATURE <i>Dr. W. Doerner, M.D.</i>								
PHYSICIAN'S NAME (Type) <b>Dr. W. Doerner, M.D.</b>						Algonquin Hotel		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>2007 Cemetery</b>		22d. LOCATION (City, town, or county) <b>Elmstone</b>		(State) <b>MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hafer</i>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>REG'D 29-58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>		

STATE OF HAWAII - DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

DEATH CERTIFICATE NO.	ISSUED BY	REGISTRATION NO.
NAME OF DECEASED	ADDRESS	PHONE NO.
SEX	AGE	CAUSE OF DEATH
DATE OF DEATH	TIME	PLACE
CERTIFYING PHYSICIAN		
RECEIVED BY		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8600

## CERTIFICATE OF DEATH

Reg. Dist. No.

08602

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>34 HOURS</b>	
d. NAME OF HOSPITAL OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>		e. STREET ADDRESS <b>LA VALE 19 OAKLAWN AVE.,</b>	
3. NAME OF DECEASED (Type or print) <b>BABY</b>		First <b>BABY</b>	Middle <b>GIRL</b>
4. DATE OF DEATH <b>AUGUST 7 1958.</b>		Last <b>IRON</b>	Month <b>AUGUST</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 6, 1958.</b>
9. AGE (In years last birthday) yrs. <b>1</b>	10. IF UNDER 1 YEAR Months <b>1</b>	11. IF UNDER 24 HRS. Days <b>10</b>	12. IF UNDER 24 HRS. Hours <b>23</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY: <b>U. S. A.</b>	
13. FATHER'S NAME <b>CLAUDE IRONS</b>		14. MOTHER'S MAIDEN NAME <b>KATHLEEN F. HOSMER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>773.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-6</b> , 19 <b>58</b> , to <b>8-7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8-7</b> , 19 <b>58</b> , and that death occurred at <b>5:35 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>8/9/58.</b>	
ACTUAL SIGNATURE <b>W.R. Hodges</b>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/14/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>RoseHill Cemetery</b>
22d. LOCATION (City, town, or county) <b>Smethport, Pa</b>		24a. REC'D BY REGISTRAR <b>Arthur Steury</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>	24b. REGISTRAR'S SIGNATURE
		DATE <b>AUG 12 1958</b>	

0060223XV2

THE STATE OF SOUTH DAKOTA - SECTION 10

CERTIFICATE OF DEATH

WITNESS

MAURICE

THE

DEATH

ON

MAY

DECEASED

and being so informed I declare that

the above named deceased died on the day and month

of his/her birth as follows:

Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_

Color \_\_\_\_\_ Hair \_\_\_\_\_ Eyes \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_

Build \_\_\_\_\_ Complexion \_\_\_\_\_

Habits \_\_\_\_\_ Education \_\_\_\_\_

Occupation \_\_\_\_\_ Trade \_\_\_\_\_

Residence \_\_\_\_\_ Birthplace \_\_\_\_\_

Employer \_\_\_\_\_

1

**FOR STATE  
HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**8653 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**Reg. Dist. No. 08603**

**To DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**To FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb <b>3 ds</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mildred</b>		First <b>Betty</b>	Middle <b>Joe</b>
4. DATE OF DEATH <b>4 Aug 26 1958</b>	Month <b>Aug</b>	Day <b>26</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Oct. 24. 1927</b>	9. AGE (In years last birthday) <b>30 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
13. FATHER'S NAME <b>William Brashear</b>		14. MOTHER'S MAIDEN NAME <b>Erma Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mr. Wayne Brashear-Westernport, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Chest - Atelectasis Lungs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>40 1/2 hrs</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>825X</b>		(b) <b>Ruptured Spleen - Ruptured Liver</b>	
		(c) <b>Retro Peritoneal Hematoma</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture Left Forearm. Fracture RT 1st Toe</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident</b>	
20c. TIME OF INJURY Hour <b>5:30</b> p.m. <b>Aug 24 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Highway</b>	
20e. PLACE OF INJURY (Home, farm, factory/street, office bldg., etc.) <b>near Lonaconing Allegany</b>		20f. (City or town) (County) (State) <b>Allegany Ct. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W.O. McLane</b>		DATE SIGNED <b>Aug 26 1958</b>	
EXAMINER'S NAME (Type) <b>W.O. McLane MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 28, 58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Miller Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Allegany Ct. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E.J. Bival</b>		ADDRESS <b>Westernport, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>AUG 28 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>C. E. Bival &amp; Sons</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08604

8601

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>43 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL (If not in hospital, give address or institution) <b>WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.</b>				d. STREET ADDRESS <b>126 SPRINGDALE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>LIZZIE</b>		First	Middle	Last	4. DATE OF DEATH <b>AUGUST 4 1958</b>	Month	Day	Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 3, 1884</b>	9. AGE (In years lost birthday) <b>74 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>INDIANA - RICHMOND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>JAMES YUTZ</b>				14. MOTHER'S MAIDEN NAME <b>LUCY GRIMSLY</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>194X</b>		DUE TO <b>Macrocystis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <b>Adenos-Carcinoma of Stomach</b>						
(c)		<b>Carcinomatous</b>		5 mon.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>June 25, 1958</b> to <b>Aug. 4, 1958</b> , that I last saw the deceased alive on <b>Aug. 4, 1958</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>		DATE SIGNED <b>8/5/58</b>		
ACTUAL SIGNATURE <b>Clay E. Durrett</b>		M.D.						
PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-7-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>AUG 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. Smith</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08605

8602

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>8/21/58</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>23 Church Hill St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Maria</b>		First	Middle	Last	4. DATE OF DEATH <b>Lamb</b>	Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>8/25/1871</b>	9. AGE (In years (In months/birthday) <b>87 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John Humphery</b>		14. MOTHER'S MAIDEN NAME <b>Isabel Clarkson</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>P.O.Box 599</b>		Address <b>Cumberland, Md.</b>			
				<b>Allegany County Infirmary Records</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X</b> DUE TO <i>Chronic myocarditis</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Cerebral arteriosclerosis</i>									
DUE TO (c) <i>Chronic nephritis</i>									
INTERVAL BETWEEN ONSET AND DEATH ?									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ascites</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>49 Greene St.</b>		(County) <b>Cumberland, Md.</b>	(State) <b>MD.</b>
21. I certify that I attended the deceased from <b>8/21/58</b> , 19, to <b>8/26/58</b> , 19, that I last saw the deceased alive on <b>8/25/58</b> , 19, and that death occurred at <b>7:30A</b> M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>49 Greene St.</b>									
DATE SIGNED <b>8/26/58</b>									
ACTUAL SIGNATURE <i>James E. McLean</i>		PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/28/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Frostburg, MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b>		ADDRESS <b>LONACONING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 28 '58</b>		24b. REGISTRAR'S SIGNATURE <i>James E. McLean</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

State of

Illino

is dead

on July 1,

in the year of our Lord, one thousand nine hundred and twenty seven.

John J. Smith

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8603 CERTIFICATE OF DEATH

08606

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>30 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		d. STREET ADDRESS <b>300 OLDTOWN ROAD</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>REV. LAWRENCE</b>		First	Middle	Last	<b>LANDRIGAN</b>	4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>17</b>	Year <b>1958</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>1/12/1889</b>	9. AGE (in years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRIEST -PASTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Catholic Church</b>		11. BIRTHPLACE (State or foreign country) <b>MASS. (EVERETT)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Montague Landrigan</b>				14. MOTHER'S MAIDEN NAME <b>Mary Murphy</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-36-9398</b>		17. INFORMANT <b>PATIENTS CHART</b>		Address			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>16 hrs</i></p> <p>422.1 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Arteriosclerotic Cardio. Vascular Disease</i> 3 yrs</p> <p>DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Alcohol</i></p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Alcohol</i>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
<p>21. I certify that I attended the deceased from <i>12 July, 1958</i>, to <i>17 Aug, 1958</i>, that I last saw the deceased alive on <i>17 Aug, 1958</i>, and that death occurred at <i>5:15 P.M.</i>, from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) <i>122 S. Centre St., Cumberland, Md.</i> DATE SIGNED <i>17 Aug, 1958</i></p>									
ACTUAL SIGNATURE <i>J. G. Stegmaier</i>		M.D.							
PHYSICIAN'S NAME (Type) <b>J. G. Stegmaier, M.D.</b>		122 S. Centre St., Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-21-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and can't be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08607

## CERTIFICATE OF DEATH

Reg. Dist. No.

1		8604		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.		o. COUNTY ALLEGANY		o. STATE MARYLAND	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		d. STREET ADDRESS 1 438 WALNUT ST.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNABELL		First	Middle	Lost	4. DATE OF DEATH AUGUST 29 1958
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUG. 8, 1901	9. AGE (In years lost birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home		10c. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JOHN MANUEL		14. MOTHER'S MAIDEN NAME CHARLOTTE KLINE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT PT'S CHART Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO		Acute Myocardial Failure 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		Acute Myocardial Infarction 1 day			
(c)		Atherosclerotic Heart Disease 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Obesity — Gall bladder disease			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 27, 1958, to Aug 29, 1958, that I last saw the deceased alive on Aug 28, 1958, and that death occurred at 2:10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE S. G. WEISMAN M.D.		59 Greene St. August 30, 1958			
PHYSICIAN'S NAME (Type)		Cumberland Maryland			
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 1, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Rosehill Cemetery	
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		ADDRESS		24o. REC'D BY REGISTRAR SEP 3 '58	
				24b. REGISTRAR'S SIGNATURE Charles S. Traub	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08608

8661

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G232 8-13-58 et

Reg. Dist. No.

FOR STATE  
HEALTH-DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in my event within 72 hours after death.

VS. A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. LENGTH OF STAY IN 1b <b>X Lonaconing</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Railroad Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>DAVID</b>	Middle <b>LAUDER</b>	4. DATE OF DEATH <b>Aug 5th. 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21. 1899</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automobile Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Nikep, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Lauder</b>		14. MOTHER'S MAIDEN NAME <b>Mary Eilbeck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-10-4528</b>	
17. INFORMANT		Address <b>Miss Agnes Lauder, Lonaconing, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		<b>Coronary Occlusion</b> <b>Sudden</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Coronary Sclerosis</b>		—	
(b) DUE TO <b>Coronary Sclerosis</b>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>Aug 5, 1958</i>
EXAMINER'S NAME (Type) <i>Benedict Skitarelic</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/7/1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Sunset Memorial</b>	22d. LOCATION (City, town or county) (State) <b>Cumberland, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Eichhorn, Lonaconing, MD.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>AUG 8 '58</i>
			24b. REGISTRAR'S SIGNATURE <i>Alv. Leach</i>



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing in the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08609

Reg. Dist. No.

8654

1. PLACE OF DEATH a. COUNTY  Allegany	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	c. LENGTH OF STAY IN lb 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 1, Frostburg					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miner's Hospital	d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Eugene	First Middle Layman	4. DATE OF DEATH Month Aug Day 30 Year 1958					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24th, 1875	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John N. Layman	14. MOTHER'S MAIDEN NAME Anna R. Fazenbaker	Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Doris Stonebraker, Frostburg, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
				INTERVAL BETWEEN ONSET AND DEATH 4 Days Fracture Left Femur 5 Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in back yard at his home						
20c. TIME OF INJURY Month, Day, Year Hour p. m. Aug 26 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) His yard	20f. (City or town) Frostburg	(County) allegany	(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE WOMC Lane	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Sept 1 1958		
EXAMINER'S NAME (Type) WOMC LANEMD	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-2-58	22c. NAME OF CEMETERY OR CREMATORIUM F' bg. Memorial Park	22d. LOCATION (City, town, or county) Frostburg,	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,	ADDRESS Frostburg, Md.	24a. REC'D BY REGISTRAR DATE SEP 3 '58	24b. REGISTRAR'S SIGNATURE Charles L. Evans				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08610

8605

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>7 3/4 HRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>ALLEGANY</b>	
3. NAME OF DECEASED (Type or print)	First <b>BABY</b>	Middle <b>GIRL</b>	Last <b>LEPLEY</b>
4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>2,</b>	Year <b>19 58.</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 2, 1958.</b>
9. AGE (In years last birthday) yrs. <b>7</b>	10. IF UNDER 1 YEAR Months <b>7</b>	11. IF UNDER 24 HRS. Days <b>45</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>PAUL V. LEPLEY</b>		14. MOTHER'S MAIDEN NAME <b>DELORES J. NORRIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>762.5</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Anesthesia</b> DUE TO (c) <b>Domestically</b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 3:55 PM, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
DATE SIGNED			
ACTUAL SIGNATURE <b>Pauline Brantley</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>8/3/58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Memorial Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>VS A15 (4) 15M 10/57</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 8 '58		24b. REGISTRAR'S SIGNATURE <b>Albert Smith</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08611

8655

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>24 W. College Avenue</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
d. STREET ADDRESS <b>24 W. College Avenue</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>ELIZA</b>	Middle <b>(SEMLER)</b>	Last <b>LEWIS</b>
4. DATE OF DEATH	Month <b>August</b>	Doy <b>25, 1958</b>	Year
S. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 25, 1883</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Semler</b>	
14. MOTHER'S MAIDEN NAME <b>Virginia Conner</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>215-34-4919</b>		17. INFORMANT <b>Walter Hunter, Frostburg, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>33IX</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2wks</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Cerebral Hemorrhage</b>			
(c) DUE TO <b>Hyper tension</b>		8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>260X Diabetes</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1950</b> , 19 <b>Aug 25</b> , 1958, that I last saw the deceased alive on <b>Aug 24</b> , 1958, and that death occurred at <b>2:15 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>W. O. McLane</b>		ADDRESS (Street, city or town, state) <b>E. Main St., Frostburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-27-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>F'bg. Memorial Park</b>
22d. LOCATION (City, town, or county) <b>Frostburg, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>		ADDRESS <b>Frostburg, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>AUG 28 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Koenig</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

State Department of Health - ALASKA  
Division of Public Health  
Health Statistics Branch  
Statistical Record

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08612

8656

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>12 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>MARY</b>	Middle <b></b>	Last <b>LEWIS</b>
4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>16,</b>	Year <b>1958</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-20-1876</b>
9. AGE (In years from birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS. Days <b></b>	12. IF UNDER 24 HRS. Hours <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Owen Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Porter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Edward Carter, Eckhart, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>570.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 15, 1958</b> to <b>Aug 16, 1958</b> that I last saw the deceased alive on <b>Aug 15, 1958</b> , and that death occurred at <b>6:32 AM</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>E. Main St., Frostburg, Md.</b>	
ACTUAL SIGNATURE <b>W. O. McLane, M. D.</b>		DATE SIGNED <b>Aug 16, 1958</b>	
PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-18-1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Eckhart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eckhart, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 19 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>John S. Mann</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 10/57

DEPARTMENT OF HIGHWAY - BUREAU OF STATE PLANNING

STATE OF CALIFORNIA  
DEPARTMENT OF HIGHWAY

EXHIBIT D

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08613

8606

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 20 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 328 EMILY STREET		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
3. NAME OF DECEASED (Type or print) MOLLIE		First REBECCA	Middle LIPSCOMB
4. DATE OF DEATH AUGUST 1, 1958		Month 1958	Day Year
5. SEX F	6. COLOR OR RACE W WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JULY 14, 1870
8. AGE (In years last birthday) 88 yrs.		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) HERRING, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENJAMIN V. MC MILLAN		14. MOTHER'S MAIDEN NAME CASSIE GREENLEAF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. WAYNE LIPSCOMB, CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Anteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 1:00PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leo H. Ley Jr.</i>		ADDRESS (Street, city or town, state) M.D. 456 N. Centre St., Cumberland, Md. DATE SIGNED <i>8/4/58</i>	
PHYSICIAN'S NAME (Type) LEO H. LEY Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 4, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM McNEELY CEMETERY		22d. LOCATION (City, town, or county) HENDRICKS, WEST VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. HAVER, CUMBERLAND, MARYLAND		24a. REC'D BY REGISTRAR DATE AUG 5 '58	
		24b. REGISTRAR'S SIGNATURE <i>A. L. Leach</i>	

67 | PUNISHED BY THE LAW: THE POLITICAL CRIMES OF JESSE JACKSON

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08614

8657

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		d. STREET ADDRESS <b>30 Stoyer</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>30 Stoyer</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John</b>		First	Middle <b>E.</b>	Last <b>Long</b>	4. DATE OF DEATH <b>8 9 1958</b>	Month	Day	Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>10 27 1867</b>	9. AGE (In years lost birthday) yrs. <b>90</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tin Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Md. U. S. A.</b>			
13. FATHER'S NAME <b>John Long</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Stafford</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ethel Harden,</b>		Address <b>Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1991</b>		DUE TO <b>Carcinoma right ear</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <b>c metastasis to brain.</b>							
(c) <b>Self inflicted.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>39 W Main St.</b>		20f. (City or town) <b>Frostburg</b>		(County) <b>Washington Co.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from _____		6-15, 1957, to 8-9, 1958		that I last saw the deceased alive on _____		8-9, 1958, and that death occurred at 4 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>39 W Main St., Frostburg, Md.</b>	
ACTUAL SIGNATURE <b>H.C. Diehl</b>		DATE SIGNED <b>8/10/58</b>							
PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-12-1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Hyndman Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hyndman</b>		(State) <b>Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>O.H. Mattingly</b>		ADDRESS <b>Hafer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>AUG 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knau</b>			
		Frostburg, Md.		DATE					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08615

8607

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>		d. STREET ADDRESS <b>1109 VIRGINIA AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MRS. MOLLIE CATHERINE LONG</b>		First	Middle	Last	4. DATE OF DEATH <b>AUG. 25</b>	Month	Day	Year <b>19 58</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 21, 1866</b>		9. AGE (In years last birthday) yrs. <b>91</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA-Altoona</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JAMES WESTBROOK</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN KESSER</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Arterios sclerotic Cardiovascular</i>		INTERVAL BETWEEN ONSET AND DEATH				
442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>Renal disease - with hypertension,</i>						
		(c) <i>Cardiac decompensation &amp; Cardiac failure 5 yrs +</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<i>Thrombotic vascoconstrictive hemibursal veins with bleeding</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Deceased from</i>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Cumberlnd</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Aug. 20, 1958</i> to <i>Aug 25, 1958</i> , that I last saw the deceased alive on <i>Aug 25, 1958</i> , and that death occurred at <i>7:56 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Cumberlnd</i>			DATE SIGNED <i>Aug 25 '58</i>	
ACTUAL SIGNATURE <i>Wynne M. Mayo</i>		M.D.						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 28 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>		

WATERMELON - CROWN OF THE SOUTH - CALIFORNIA

CERTIFICATE OF DATA

State of California

County of San Joaquin

City of Stockton

Planted in the Spring of 1901

Harvested in the Fall of 1901

Planted in the Spring of 1902

Harvested in the Fall of 1902

Planted in the Spring of 1903

Harvested in the Fall of 1903

Planted in the Spring of 1904

Harvested in the Fall of 1904

Planted in the Spring of 1905

Harvested in the Fall of 1905

Planted in the Spring of 1906

Harvested in the Fall of 1906

Planted in the Spring of 1907

Harvested in the Fall of 1907

Planted in the Spring of 1908

Harvested in the Fall of 1908

Planted in the Spring of 1909

Harvested in the Fall of 1909

Planted in the Spring of 1910

Harvested in the Fall of 1910

Planted in the Spring of 1911

Harvested in the Fall of 1911

Planted in the Spring of 1912

Harvested in the Fall of 1912

Planted in the Spring of 1913

Harvested in the Fall of 1913

Planted in the Spring of 1914

Harvested in the Fall of 1914

Planted in the Spring of 1915

Harvested in the Fall of 1915

Planted in the Spring of 1916

Harvested in the Fall of 1916

Planted in the Spring of 1917

Harvested in the Fall of 1917

Planted in the Spring of 1918

Harvested in the Fall of 1918

Planted in the Spring of 1919

Harvested in the Fall of 1919

Planted in the Spring of 1920

Harvested in the Fall of 1920

Planted in the Spring of 1921

Harvested in the Fall of 1921

Planted in the Spring of 1922

Harvested in the Fall of 1922

Planted in the Spring of 1923

Harvested in the Fall of 1923

Planted in the Spring of 1924

Harvested in the Fall of 1924

Planted in the Spring of 1925

Harvested in the Fall of 1925

Planted in the Spring of 1926

Harvested in the Fall of 1926

Planted in the Spring of 1927

Harvested in the Fall of 1927

Planted in the Spring of 1928

Harvested in the Fall of 1928

Planted in the Spring of 1929

Harvested in the Fall of 1929

Planted in the Spring of 1930

Harvested in the Fall of 1930

Planted in the Spring of 1931

Harvested in the Fall of 1931

Planted in the Spring of 1932

Harvested in the Fall of 1932

Planted in the Spring of 1933

Harvested in the Fall of 1933

Planted in the Spring of 1934

Harvested in the Fall of 1934

Planted in the Spring of 1935

Harvested in the Fall of 1935

RECORDED IN 1936

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8608

## CERTIFICATE OF DEATH

Reg. Dist. No.

08616

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>13 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLERSLIE</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>LUCINDA</b>	Middle <b>LOWERY</b>	Last <b>LOWERY</b>	4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>26</b>	Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>OCTOBER 29, 1878</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>EMANUEL A. LOWERY</b>		14. MOTHER'S MAIDEN NAME <b>SARA WITT</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>570.5</b>		DUE TO <b>massive Pulmonary Embol.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>deceased</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <b>Gall stone obstr. of ileum</b>		1/2x before op.				
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>extreme post-op (oper Aug 17/58)</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>Aug</b>	Day <b>13</b>	Year <b>19 58</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Lyndman Rd.</b>	(County) <b>None</b>	(State) <b>Pa</b>
21. I certify that I attended the deceased from <b>Aug 13, 19 58</b> , to <b>Aug 26, 19 58</b> , that I last saw the deceased alive on <b>Aug 26, 19 58</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Dr. Mirkin</i>		M.D.		ADDRESS (Street, city or town, state) <b>45 So. Centre St.</b>		DATE SIGNED <b>Aug 26, 19 58</b>		
PHYSICIAN'S NAME (Type) <b>DR. A.J. MIRKIN</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-31-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Pala Alto Cemetery</b>		22d. LOCATION (City, town, or county) <b>Lyndman Rd.</b>		(State) <b>Pa</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>negative</i>		ADDRESS <b>lyndman Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 3 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08617

8609

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oldtown Maryland</i>		d. STREET ADDRESS <i>Oldtown Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>				d. STREET ADDRESS <i>Oldtown</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Joseph</i>	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Sept 29 1873</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Finch Farm.</i>		11. BIRTHPLACE (State or foreign country) <i>Oldtown MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Rudolph Luteman</i>		14. MOTHER'S MAIDEN NAME <i>Evaline Zweig</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. Evelyn Myrly, Gransing, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i> DUE TO <i>Embolism or rupture, Cerebral</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 days.</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis General</i> DUE TO <i>—</i> 10-20 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-23-58</i> , 19 <i>—</i> , to <i>—</i> , 19 <i>—</i> , that I last saw the deceased alive on <i>8-23-58</i> , 19 <i>—</i> , and that death occurred at <i>II A. M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Paw Paw, W. Va.</i> DATE SIGNED <i>8-28-58.</i>							
ACTUAL SIGNATURE <i>J. I. Armstrong</i>		M.D.					
PHYSICIAN'S NAME (Type) <i>J. I. Armstrong</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/30/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Oldtown Cemetery</i>		22d. LOCATION (City, town, or county) <i>Oldtown Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc. Cumb. Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
VS A15 (4) 15M 9/55				DATE <i>SEP 2 '58</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08618

1		8610		CERTIFICATE OF DEATH				
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.								
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.								
1. PLACE OF DEATH a. COUNTY  Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/23/57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 315 Pennsylvania Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Ora	Middle P. e.	Last Markwood	4. DATE OF DEATH August 20, 1958	Month August	Day 20	Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/2/1875	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own House		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John W. Morrison		14. MOTHER'S MAIDEN NAME Hannah Newcomb						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT P.O. Box 599 Allegany County Infirmary Records		Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2		DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Left hemiplegia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 49 Greene St.		20f. (City or town) Cumberland, Md.	(County) Md.	
21. I certify that I attended the deceased from 9/23/57, 19, to 8/20/58, 19, that I last saw the deceased alive on 8/20/58, 19, and that death occurred at 3:20 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 49 Greene St.		DATE SIGNED 8/20/58		
ACTUAL SIGNATURE Dr. James E. McLean								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 22 1958		22c. NAME OF CEMETERY OR CREMATORIUM Burlington Cemetery		22d. LOCATION (City, town, or county) Burlington, W. Va. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE William P. Right		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE AUG 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		





FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "Pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8611 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>1604 Frederick St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1604 Frederick St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>DAVID</b>		First <b>WILLIAM</b>	Middle <b>MASON</b>	Last	4. DATE OF DEATH <b>Aug. 16,</b>	Month <b>1958</b>	Doy	Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 15, 1880</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>St. George, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>John Mason</b>				14. MOTHER'S MAIDEN NAME <b>Isabella Close</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Spanish Am. 214-05-4351</b>		17. INFORMANT <b>Donald W. Mason -- Cumberland, Maryland</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion							
4/20/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Coronary Sclerosis							
(b) DUE TO (a), stating the underlying cause lost.									
(c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cumberland</b>	(County) <b>Allegany</b>	(State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>August 17, 1958</b>				
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/19/1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>HillCrest Burial Park</b>	22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR <b>AUG 20 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>					

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 should be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08620

8612

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	b. COUNTY <b>Allegany</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	c. LENGTH OF STAY IN 1b <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	d. STREET ADDRESS <b>1 267 Williams St.</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bow Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Arch</b>	First <b>Arch</b>	Middle <b>Mathews</b>	Last <b>August 12 1958</b>
4. DATE OF DEATH <b>Sept. 15, 1897</b>	Month <b>August</b>	Day <b>12</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1897</b>
9. AGE (In years last birthday) <b>60 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>House painting</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles H. Mathews</b>	14. MOTHER'S MAIDEN NAME <b>Mary Martz</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>220 26 7609</b>	17. INFORMANT <b>Ruth Mathews</b>	Address <b>Cumberland, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rupture of Arteriosclerotic Aortic Aneurysm..</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	August 12, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/14/1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Peter &amp; Pauls Cem.</b>	22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>	ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR <b>AUG 14 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

NEW YORK  
STATE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED PERSON'S NAME	AGE	SEX	CAUSE OF DEATH
John Doe	50	Male	Heart Disease
ADDRESS	DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH
123 Main Street	1967	10:00 AM	Hospital
NAME AND ADDRESS OF PHYSICIAN	NAME AND ADDRESS OF HOSPITAL	NAME AND ADDRESS OF FUNERAL DIRECTOR	
Dr. John Smith, 123 Main Street	Hospital, 123 Main Street	Funeral Home, 123 Main Street	
I declare under penalty of perjury that the information contained in this certificate is true and correct.			
<input type="checkbox"/> I am a physician.			
<input type="checkbox"/> I am a medical examiner.			
<input type="checkbox"/> I am a coroner.			
<input type="checkbox"/> I am a funeral director.			
<input type="checkbox"/> I am a layman.			

RECORDED AND INDEXED  
MAY 1967  
FBI - NEW YORK

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08621

8613

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>6/12/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS <b>608 Hill Top Drive</b>	
3. NAME OF DECEASED (Type or print)	First <b>Alfred</b>	Middle	Last <b>McKenzie</b>
4. DATE OF DEATH <b>August 4, 1958</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>9/30/1875</b>
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <b>82 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - B&amp;O R. R. Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
13. FATHER'S NAME <b>Moses McKenzie</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>705-12-3717</b>	17. INFORMANT P.O. Box 599 Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary Records</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Pulmonary Hypostasis</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Chronic Myocarditis</b> ? (c) DUE TO <b>Cerebral arteriosclerosis</b> ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senile deterioration</b>			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20e. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/12/58</b> , 19, to <b>8/4/58</b> , 19, that I last saw the deceased alive on <b>8/4/58</b> , 19, and that death occurred at <b>3:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>James E. McLean</i>		22. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b> 22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b> 22e. DATE SIGNED <b>8/5/58</b>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22c. DATE THEREOF <b>Aug. 7, 1958</b>	
22d. NAME OF CEMETERY OR CREMATORIAL <b>HILLCREST BURIAL PARK</b>		22e. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>A. L. Seach</b> 24b. REGISTRAR'S SIGNATURE <b>A. L. Seach</b> DATE <b>AUG 11 '58</b>	

## CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	
EDWARD J. HANLEY	52	Male	Cardiac Disease	
ADDRESS	STREET	CITY	STATE	
100 W. 10th Street	10th	Madison	Wisconsin	
NAME OF DOCTOR	STREET	CITY	STATE	
DR. R. L. COOPER	10th	Madison	Wisconsin	
NAME OF FUNERAL DIRECTOR	STREET	CITY	STATE	
WILLIAMS FUNERAL HOME	10th	Madison	Wisconsin	
DATE OF DEATH	TIME	DAY	MONTH	YEAR
Sept. 20, 1958	10:30 P.M.	Saturday	September	1958
TIME OF BURIAL	TIME OF CREMATION	TIME OF AUTOPSY	TIME OF EXAMINATION	
11:00 A.M.	11:00 A.M.	11:00 A.M.	11:00 A.M.	
NAME OF PERSON SIGNING	STREET	CITY	STATE	
DR. R. L. COOPER	10th	Madison	Wisconsin	
POSITION	STREET	CITY	STATE	
WILLIAMS FUNERAL HOME	10th	Madison	Wisconsin	
NAME OF PERSON SIGNING	STREET	CITY	STATE	
DR. R. L. COOPER	10th	Madison	Wisconsin	
POSITION	STREET	CITY	STATE	
WILLIAMS FUNERAL HOME	10th	Madison	Wisconsin	

14  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08622

Reg. Dist. No.

8614

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Mineral</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.D. #1 Ridgely, West Virginia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>85X3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>									
3. NAME OF DECEASED (Type or print)		First <b>Charles Edward</b>	Middle <b>Messick</b>	Lost	4. DATE OF DEATH	Month <b>August</b>	Doy <b>23</b>	Year <b>1958</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 15, 1932</b>	9. AGE (In years lost by day) <b>25 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Salesman Food Products</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Charles Messick</b>		14. MOTHER'S MAIDEN NAME <b>Hazel White</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1950-1953 B32 48 1743</b>		17. INFORMANT <b>Mrs. Dorothy Messick-Rt. 1, Ridgely, W. Va.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemothorax</b> DUE TO Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause lost. (b) <b>Crushed Chest</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>20 Minutes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Ruptured Liver</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident</b>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>1:30 PM Aug. 23 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) <b>Near Ridgely, Mineral, W. Va.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>August 23, 1958</b>					
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 25, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Davis Memorial Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>AUG 27 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Caroline S. Koraad</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8615

## CERTIFICATE OF DEATH

Reg. Dist. No.

08623

1. PLACE OF DEATH o COUNTY <b>ALLEGANY</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>	b. COUNTY <b>ALLEGANY</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BARTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK-MEMORIAL MEMORIAL HOSPITAL-AVE.</b>		d. STREET ADDRESS <b>/</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

60

3. NAME OF DECEASED (Type or print)	First <b>MARGARET</b>	Middle <b>M.</b>	Last <b>METZ</b>	4. DATE OF DEATH <b>AUGUST 4 1958</b>
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S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 3</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BARTON, MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13. FATHER'S NAME <b>OATHE INSKEEP</b>	14. MOTHER'S MAIDEN NAME <b>SARAH RUSSELL</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>MEMORIAL HOSPITAL</b>	Address <b>CUMBERLAND, MARYLAND</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Cervix uteri - Extensive</b> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) <b>Unilateral obstruction with Uterus</b> DUE TO (c) <b>Carcinoma</b>	<b>3+ years</b>
	<b>6 months</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>July</b> , 1958, to <b>Aug 4</b> , 1958, that I last saw the deceased alive on <b>Aug 4</b> , 1958, and that death occurred at <b>3:10 PM</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Cumberland, Md</b>	DATE SIGNED <b>Aug 5, 1958</b>
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ACTUAL SIGNATURE <b>Dr. Wylie Faw</b>	M.D.
PHYSICIAN'S NAME (Type)	DR. WYLIE FAW

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/7/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Saint Paul</b>	22d. LOCATION (City, town, or county) <b>Moscow</b> (State) <b>MD</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Oval-Westminster</b>	ADDRESS <b>101 W. Baltimore St.</b>	24a. REC'D BY REGISTRAR <b>Aug 11 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Archaeologist</b>
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01 FEBRUARY - 1961 - STATE OF HAWAII - COUNTY OF MAUI

CERTIFICATE OF PAPER

MAILED ON THIS DAY

OF THE MONTH OF FEBRUARY

IN THE YEAR OF ONE THOUSAND EIGHTY-EIGHT

BY THE POSTMASTER OF THE CITY OF HONOLULU

TO THE ADDRESS OF THE RECIPIENT

AS STATED ON THE ENVELOPE

IN THE CITY OF HONOLULU

BY THE POSTMASTER OF THE CITY OF HONOLULU

TO THE ADDRESS OF THE RECIPIENT

AS STATED ON THE ENVELOPE

IN THE CITY OF HONOLULU

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AS STATED ON THE ENVELOPE

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AS STATED ON THE ENVELOPE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8616

## CERTIFICATE OF DEATH

Reg. Dist. No.

08624

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>40 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>524 Columbia Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bernetta Virginia Miller</b>		First <b>Bernetta</b>	Middle <b>Virginia</b>
4. DATE OF DEATH <b>8 16 1958</b>		Month <b>8</b>	Day <b>16</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>Nov. 8, 1914</b>		9. AGE (In years lost birthday) <b>43</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>
11. BIRTHPLACE (State or foreign country) <b>Ridgeley, W. Va.</b>		12. IF UNDER 24 HRS. Days <b>0</b>	13. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Eva B. See</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-4151</b>	17. INFORMANT <b>Mrs. Eva B. See, Cumberland, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that I attended the deceased from <b>JULY 1953</b> to <b>AUG. 1958</b> , that I last saw the deceased alive on <b>AUG. 11, 1958</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE 		ADDRESS (Street, city or town, state) <b>Mercy Hospital</b> <b>CUMBERLAND MD.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Frank T. Cawley</b>		DATE SIGNED <b>8-18-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-21-1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>
22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JULY 19 1958</b>	24b. REGISTRAR'S SIGNATURE <b>Caroline S. Knudsen</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DEPARTMENT OF HEALTH—SERIAL NUMBER 18

CERTIFICATE OF DEATH

1960

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film C233 8-27-58 et

08625

## CERTIFICATE OF DEATH

Reg. Dist. No.

8658

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		d. STREET ADDRESS <b>High Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MATTHEW</b>	Middle <b>MUIR</b>	Last 4. DATE OF DEATH <b>AUGUST 14 1958</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 16th. 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman V.F.W. Club</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Lonaconing MD</b>
13. FATHER'S NAME <b>William Muir</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-05-5737</b>	17. INFORMANT <b>Mrs. Emma Muir Lonaconing, MD.</b>
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162.1</b>		(WIFE) <b>Bronchogenic carcinoma</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 13, 1958</b> , to <b>Aug 14, 1958</b> that I last saw the deceased alive on <b>Aug 14, 1958</b> , and that death occurred at <b>4 a.m.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Lonaconing Md</b>	
ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b>		DATE SIGNED <b>Aug 15, 1958</b>	
PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/16/1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Sunset Memorial Park</b>	22d. LOCATION (City, town, or county) <b>Cumberland, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b>		24a. REC'D BY REGISTRAR DATE <b>Aug 18 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>
VS A15 (4) 1SM 9/SS			

81-39047-971AG-DO THE UNPRAVED STATE OF MARYLAND

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG232 8-18-58 et

08626

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, 56 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		d. STREET ADDRESS 1 INDEPENDENCE ST. EXT.	
3. NAME OF DECEASED (Type or print) SADIE ROSE MULLAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH AUGUST 8, 1958		Month Day Year	
5. SEX FEMALE WHITE WIDOWED DIVORCED		6. COLOR OR RACE NEVER MARRIED <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> B. DATE OF BIRTH APRIL 5, 1877	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH APRIL 5, 1877		9. AGE (In years lost <sup>1</sup> /birthday) 81 02 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM MULLAN		14. MOTHER'S MAIDEN NAME ANNA CARLOS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Terminal Broncho Pneumonia 5 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Carcinomatosis of Spine, Lung 1 yr.			
(c) DUE TO Carcinoma of Right Breast 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY, Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1953, to Aug 8, 1958, that I last saw the deceased alive on Aug 8, 1958, and that death occurred at 4:35 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 59 Greene St Cumberland, Md. DATE SIGNED 8/8/58	
ACTUAL SIGNATURE DR. S. G. WEISMAN M.D.			
PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 11, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM St. Peter & Pauls Cem.		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR AUG 12 1958		24b. REGISTRAR'S SIGNATURE Arthur J. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEVELOPMENT DEPARTMENT - ALTHOME

## CERTIFICATE OF DEATH

NAME

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08627

8618

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>1021 Harding Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Ellis Ray Northcraft</b>		First <b>Ellis</b>	Middle <b>Ray</b>
4. DATE OF DEATH <b>August 15 1958</b>	Month <b>August</b>	Day <b>15</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/7/88</b>
9. AGE (In years last birthday) <b>69 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
13. FATHER'S NAME <b>Retired</b>	14. MOTHER'S MAIDEN NAME <b>Patrick Northcraft</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>214-05-8017</b>		17. INFORMANT <b>Patient's chart.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b>		4 yrs	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchial Asthma</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that I attended the deceased from <b>May 1958</b> to <b>August 1 1958</b> that I last saw the deceased alive on <b>July 31 1958</b> , and that death occurred <b>11:18 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>441 N. Centre St.</b> DATE SIGNED <b>8/18/58</b>			
ACTUAL SIGNATURE <b>William P. James</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>William P. James, M.D.</b>		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug 18 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Sunset Memorial Cemetery</b>	22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		ADDRESS <b>Cumberland Md.</b>	24a. REC'D BY REGISTRAR DATE <b>AUG 19 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAXIMUM STABILIZATION OF HIGH-LEVEL WASTE

CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08628

## CERTIFICATE OF DEATH

Reg. Dist. No.

8619

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>37 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>					
d. NAME OF HOSPITAL (If not in hospital, give address) OR INSTITUTION <b>WARWICK AND MEMORIAL HOSPITAL - MEMORIAL AVE.</b>		d. STREET ADDRESS <b>878 SPERRY TERRACE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First <b>B.</b>	Middle <b>ORT</b>	Last <b>ORT</b>	4. DATE OF DEATH <b>AUGUST 28 1958</b>	Month <b>AUGUST</b>	Day <b>28</b>	Year <b>1958</b>	
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 28 1887</b>	9. AGE (In years lost birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Machinist</b>		11. BIRTHPLACE (State or foreign country) <b>FROSTBURG, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>BENJAMIN ORT</b>		Helper		14. MOTHER'S MAIDEN NAME <b>MARGARET BRODE</b>		Address <b>CUMBERLAND, MD.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-05-5332</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>523.0</b> DUE TO <b>Ventricular dilatation myocardial</b> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> ONSET AND DEATH <b>48 hrs</b> (c) <b>Silicosis</b> <b>very 2 months</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D.</b>		20f. (City or town) <b>Frostburg</b>		(County) <b>Washington</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>3/1/58</b> , 19, to <b>8/28/58</b> , 19, that I last saw the deceased alive on <b>8/28/58</b> , 19, and that death occurred at <b>10:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>378 Sperry Terrace, Cumberland, Maryland</b>									
ACTUAL SIGNATURE <b>R. J. Williams</b>		DATE SIGNED <b>8/28/58</b>							
PHYSICIAN'S NAME (Type) <b>DR. RICHARD J. WILLIAMS</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 31.1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Frostburg Mem. Park</b>		22d. LOCATION (City, town, or county) <b>Frostburg, Maryland</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>SEP 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



1 FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

V.S. A15ME  
BM 2/27

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8620 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7 Bellevue Street</b>				d. STREET ADDRESS <b>7 Bellevue Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>John Parch</b>		First	Middle	Last	4. DATE OF DEATH <b>August 12, 1958</b>	Month	Doy	Year					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1889</b>	9. AGE (In years last birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>K-S Tire Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Rome, Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>W W I 217-10-6638</b>		17. INFORMANT <b>Mrs. Virginia McBee</b>		Address <b>943 Gay Street Cumberland, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		GUNSHOT wound of head				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)	Self inflicted										
DUE TO		DUE TO											
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Suicide</b>											
20c. TIME OF INJURY Hour <b>2:30</b> p.m.		Month, Day, Year <b>8 - 12 1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Cumberland, alleg, Md.</b>	(County)	(State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>August 14, 1958</b>							
EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 15, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Trahan</b>							

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118630

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

8621

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3mos</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7 Bellevue Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
3. NAME OF DECEASED (Type or print) <b>MARGARET</b>		d. STREET ADDRESS <b>1 7 Bellevue Street</b>	
First <b>LILLIAN</b>		Middle <b>PARCH</b>	Last 4. DATE OF DEATH <b>August 12</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH <b>March 2, 1918</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Barney S. Nichols</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Harvey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>569-32-2090</b>	
17. INFORMANT <b>Mrs. Virginia McBee</b>		943 Gay Street Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Skull</b>  983X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Hammer blows (Homicide.)</b>  DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Killed by husband.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour <b>8-12 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Cumberland, Alleg., Md.</b>		(County) <b>Calvert</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>		August 14, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>August 15, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Hillcrest Bur. Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE <b>AUG 19 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Orlmaus S. Kraus</b>	

REVIEW OF THE EXAMINER'S REPORT

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8622

## CERTIFICATE OF DEATH

08631

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>913 Maryland Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>RAYMOND</b>		First <b>LEE</b>	Middle <b>PRYOR</b>	Lost	4. DATE OF DEATH <b>AUGUST 18 1958</b>	Month <b>AUGUST</b>	Day <b>18</b>	Year <b>1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 1ST, -1887</b>	9. AGE (In years lost birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR <b>Months</b>	IF UNDER 24 HRS. <b>Days</b>	Hours <b>Hours</b>	Min. <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WM Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Cumberland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Hanna</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Patient's Chart								
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Progressive Bulbar Paralysis</i> DUE TO <i>420.0</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Arterosclerotic Cardio-Vasc. Disease</i> (c) 2 yrs</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
<p>21. I certify that I attended the deceased from <i>Mar. 18, 1958</i>, to <i>Aug. 18, 1958</i>, that I last saw the deceased alive on <i>Aug. 18, 1958</i>, and that death occurred at <i>Maryland</i>, from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) <i>Cumberland, Maryland</i> DATE SIGNED <i>Aug. 19, 1958</i></p>								
<p>ACTUAL SIGNATURE <i>Clay E. Durrett</i> M.D.</p> <p>PHYSICIAN'S NAME (Type) <b>Clay E. Durrett M.D.</b> Va. Avenue, Cumberland, Maryland</p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 19, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Davis Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Allegany County, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS <b>"</b>				24a. REC'D BY REGISTRAR <b>Aug. 21 '58</b>		
						24b. REGISTRAR'S SIGNATURE <b>Clarence L. Hafer</b>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08632

8623

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2		3		4		5		6		7		8		9		10		11		12	
PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <b>208 PIEDMONT AVE.</b>		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. LENGTH OF STAY IN 1b <b>RURAL</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>208 PIEDMONT AVE.</b>																			
NAME OF DECEASED (Type or print) <b>BENNO</b>		First      Middle      Last <b>RAPP</b>		DATE OF DEATH <b>AUGUST 10 1958</b>		Month      Day      Year																	
SEX <b>MALE</b>		COLOR OR RACE <b>WHITE</b>		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		DATE OF BIRTH <b>8-20-1895</b>		AGE (In years lost birthday) yrs. <b>63</b>		IF UNDER 1 YEAR Months      Days		IF UNDER 24 HRS. Hours      Min.											
USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broker</b>		KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		BIRTHPLACE (State or foreign country) <b>GERMANY, Frankfurt</b>		CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>																	
FATHER'S NAME <b>MORITZ RAPPIN</b>		DECEASED		MOTHER'S MAIDEN NAME <b>EMMA BERBERICH</b>		(DECEASED)																	
WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		SOCIAL SECURITY NO. <b>Nond</b>		INFORMANT <b>Mrs. Norman Kline 208 Piedmont Ave., Cumberland, Md.</b>																			
CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>		DUE TO <i>acute coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>extremophile heart disease</b>		DUE TO (c) <b>generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>concurrent stomach with liver metastasis</b>				WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																					
TIME OF INJURY Hour o. m. p. m. <b>19</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(City or town) <b>57 Greene St.</b>		(County) <b>Cumberland, Md.</b>		(State) <b>Md.</b>													
I certify that I attended the deceased from <b>8-4 1958</b> , to <b>8-10 1958</b> , that I last saw the deceased alive on <b>8-10 1958</b> , and that death occurred at <b>57 Greene St.</b> M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>57 Greene St.</b>		DATE SIGNED <b>8-11-58</b>																	
ACTUAL SIGNATURE <i>L. Brings</i>		M.D.																					
PHYSICIAN'S NAME (Type) <b>Lewis Brings M.D.</b>		Cumberland, Md.																					
BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Aug. 11, 1958</b>		NAME OF CEMETERY OR CREMATORIUM <b>East View Cemetery</b>		LOCATION (City, town, or county) <b>Cumberland, Md.</b>																	
FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		ADDRESS		REC'D BY REGISTRAR DATE <b>AUG 13 '58</b>		REGISTRAR'S SIGNATURE <b>Arthur S. Haas</b>																	

STATE OF CALIFORNIA - DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G2339-2-58 et

08633

## CERTIFICATE OF DEATH

Reg. Dist. No.

8624

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>Dead on arrival</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		d. STREET ADDRESS <b>1500 Hilltop Drive</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First	Middle	Last	4. DATE OF DEATH <b>Elizabeth Reed Aug. 7 1958</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1885 April 11, 1875</b>	9. AGE (in years last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John W. Walsh</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Messman</b>				Address <b>Cumberland, Md.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Robert W. Reed</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Hypertension</b>		DUE TO <b>Obesity</b>		Coronary Thrombosis				
(b)		DUE TO		<b>5 yrs</b>				
(c)				<b>10 yrs</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D.</b>		20f. (City or town) <b>Cumberland</b>		(County) <b>Md.</b> (State)
21. I certify that I attended the deceased from <b>Aug. 4, 1958</b> , to <b>Aug. 7, 1958</b> , that I last saw the deceased alive on <b>Aug. 4, 1958</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>		DATE SIGNED <b>8/9/58</b>		
ACTUAL SIGNATURE <b>Clay E. Forrest</b>								
PHYSICIAN'S NAME (Type) <b>Sons Stein, Inc. Cumberland, Md.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 11, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sons Stein, Inc. Cumberland, Md.</b>		ADDRESS		24a. REC REGISTRATION <b>REG. 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANUFACTURED BY THE NATIONAL OIL MILLS - BIRMINGHAM, ENGLAND

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08634

8625

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>44 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>306 Park Street</b>		d. STREET ADDRESS <b>306 Park Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>R.</b>	4. DATE OF DEATH <b>August 6 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 14, 1880</b>
9. AGE (In years lost birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired telegraph operator - W-Md</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Ambrose P. Ricker</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Conner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-7872</b>	
17. INFORMANT <b>Mrs. Mary Ricker</b>		Address <b>Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b>		<i>Pulmonary edema</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		<i>Genuvald arteriosclerosis</i>	
DUE TO (c)		<i>Probable coronary thrombosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1953</b> , to <b>Aug 6 1958</b> , that I last saw the deceased alive on <b>Aug 6 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>George M. Simons</i>			
PHYSICIAN'S NAME (Type) <b>George M. Simons, M.D.</b>		<i>Cumberland, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 9/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>	
24a. REC'D BY REGISTRAR <b>JULY 11 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Albert Schuch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08635

8628

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>		d. STREET ADDRESS <b>FLINTSTONE</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>BLANCHE</b>	Middle	Last <b>ROBINETTE</b>	4. DATE OF DEATH <b>AUGUST 25</b>	Month	Day	Year <b>1958</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>APRIL 10, 1888</b>	9. AGE (In years lost birthday) <b>70</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Jackson M. Ash</b>				14. MOTHER'S MAIDEN NAME <b>JENNIE ASH</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>PATIENTS CHART</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>176.8</b> DUE TO <b>Coronary &amp; Virginal labor</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____								
INTERVAL BETWEEN ONSET AND DEATH <b>Two months</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Chronic Myoclonus with Decompensation</b>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While at work</b>						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>16 Greene St., Cumberland, MD</b>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 1955, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at 4:40A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>J. T. Johnson</i>		ADDRESS (Street, city or town, state) <b>16 Greene St., Cumberland, MD</b>						
PHYSICIAN'S NAME (Type) <b>JAMES T. JOHNSON, JR., M.D.</b>		DATE SIGNED <b>8-27-58</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/27/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Odd Fellows Cemetery</b>		22d. LOCATION (City, town, or county) <b>Flintstone Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox Cumberland Maryland</b>					24a. REC'D BY REGISTRAR DATE <b>AUG 28 '58</b>			
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08636

8627

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		d. STREET ADDRESS <b>13 N. Lee Street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13 N. Lee Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ELVA</b>		First <b>C.</b>	Middle <b>SCOTT</b>	Last <b>SCOTT</b>	4. DATE OF DEATH <b>8</b>	Month <b>8</b>	Day <b>29</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	8. DATE OF BIRTH <b>June 2, 1882</b>	9. AGE (In years lost birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>76</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Scott Lantz</b>		Address <b>Hagerstown, Md.</b>		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b></p> <p>DUE TO (c) <b>and ventricular fibrillation</b></p> <p>DUE TO (d) <b>in sleep</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>								
INTERVAL BETWEEN ONSET AND DEATH <b>dead in sleep</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
<p>21. I certify that I attended the deceased from <b>6/21/56</b>, 19, to <b>8/25/58</b>, 19, that I last saw the deceased alive on <b>7/25/58</b>, 19, and that death occurred at <b>at my home</b>, 1A M, from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) <b>122 S/ Centre Street</b></p> <p>DATE SIGNED <b>August 29, 58</b></p>								
<p>ACTUAL SIGNATURE <b>Richard Jones Williams M.D.</b></p> <p>PHYSICIAN'S NAME (Type) <b>Richard Jones Williams M.D.</b> <b>XXX</b> <b>Cumberland, Maryland</b></p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 08637				
8628 CERTIFICATE OF DEATH														
<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b>					<b>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</b> a. STATE <b>MARYLAND</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. LENGTH OF STAY IN 1b <b>27 days</b>					b. COUNTY <b>ALLEGANY</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FLINTSTONE</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print)		First <b>GEORGE</b>		Middle <b>Edward</b>		Last <b>SELF</b>		<b>4. DATE OF DEATH</b>		Month	Day	Year		
S. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>		8. DATE OF BIRTH <b>12- 6-1889</b>		9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cinder Man</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>			11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>BILLY SELF</b>					14. MOTHER'S MAIDEN NAME <b>CARRIE ANN MEYERS</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO.			17. INFORMANT		Address <b>PT'S CHART</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m.      19					20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County)      (State)						
21. I certify that I attended the deceased from <b>May 1, 1958</b> to <b>Sept 1, 1958</b> , that I last saw the deceased alive on <b>Sept 1, 1958</b> , and that death occurred at <b>2:15pM</b> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>B. M. Schindler M.D. 43 Glendale, Md 9-1-58</b>		DATE SIGNED <b>9-1-58</b>		
<b>MEDICAL CERTIFICATION</b>		ACTUAL SIGNATURE <b>B. M. Schindler M.D.</b>												
PHYSICIAN'S NAME (Type)		<b>B. M. SCHINDLER M. D.</b>								<b>43 GREEN ST.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Glendale Ch. of Brethren</b>				22d. LOCATION (City, town, or county) <b>Allegany Co. Maryland</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>										ADDRESS		24a. REC'D BY REGISTRAR DATE <b>SEP 3 '58</b>		
												24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>		

VERMONT STATE DEPARTMENT OF HEALTH - SALVATION ARMY

CERTIFICATE OF DEATH

NAME

DEATH DATE

AGE

SEX

ADDRESS

CAUSE OF DEATH

TIME OF DEATH

TIME OF DEATH

NAME

RELATIONSHIP

NAME

NAME

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08638

## 8629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1		H		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
				MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
FOR STATE HEALTH DEPT.		M		Reg. Dist. No.									
1. PLACE OF DEATH		a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)									
Allegany		MARYLAND		b. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Allegany									
Cumberland		Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		d. STREET ADDRESS									
D. O. A. Memorial Hospital		118 Seymour St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Doy	Year					
John		A.	Sensabaugh		August	7		1958					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Male		White		May 17, 1931	27 yrs.	Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
Shovel Operator		Stone quarry		Cumberland, Md.				USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address									
Grover A. Sensabaugh		Margaret Nesbit											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH							
Yes Korean		212-24-1405		Mr. Grover A. Sensabaugh, Cumberland		30 Min.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock													
DUE TO													
Conditions, if any, which gave rise to immediate cause (b) Abdominal hemorrhage													
DUE TO													
(c) Crushing injury													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Crushed in Landslide									
20c. TIME OF INJURY Month, Day, Year Hour o.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
9:30 Aug. 7 1958				Const. Job.		Near Cumberland, Alleg. Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				August 7, 1958					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)					
Burial		8-II-58		Sun Set Memorial Park		Cumberland, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
James F. Scarpelli, Cumberland, Md.		James F. Scarpelli,		AUG 12 1958		Arthur H. Tracy							

WAKAYAMA STATEMENT OF DEATH - GAIL R.  
DEATH DATE 28 MAY 1982

NAME TO SIGN

STATE TO  
SIGN

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08639

8630

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>8/18/56</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Grace</b>	Middle <b>S.</b>	Last <b>Shaffer</b>
4. DATE OF DEATH	Month <b>August</b>	Day <b>18,</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/11/1872</b>
9. AGE (In years lost birthday) <b>85</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Storekeeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Henry B. Shaffer</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth Sager</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT P.O. Box 599 <b>Allegany County Infirmary Records</b>	Address <b>Cumberland, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>General Hemorrhage.</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH 1 week.</span>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>General arteriosclerosis</b> ? <b>Chronic myocarditis</b> ? <b>Severe deterioration.</b> ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>8/18/56</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/18/56</b> , 19 <b>58</b> , to <b>8/18/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8/18/58</b> , 19 <b>58</b> , and that death occurred at <b>11:55 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. McLean</i>	ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>8/19/58</b>		
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>	ADDRESS <b>Cumberland, Md.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-21-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>F' bg. Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>AUG 21 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ILLINOIS - DIVISION OF MOTOR VEHICLES  
CERTIFICATE OF DEATH



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8631

## CERTIFICATE OF DEATH

Reg. Dist. No.

08640

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b>		b. COUNTY <b>HAMPSHIRE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PAW PAW</b>		d. STREET ADDRESS <b>85 X-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>WARWICK &amp; MEMORIAL AVENUES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>LONEY</b>		First	Middle <b>ELMER</b>	Last <b>SHAMBAUGH</b>	4. DATE OF DEATH <b>JULY 12, 1896.</b>	Month <b>AUGUST</b>	Day <b>19</b>	Year <b>19 58.</b>	
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>62</b> yrs.	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MAGNOLIA, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>ALBERT SHAMBAUGH</b>		14. MOTHER'S MAIDEN NAME <b>MARY WHISNER</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>442X</b>		<i>Arteria Sclerotic Cardia</i>					<b>4 yrs</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<i>basculot renal disease.</i>					<i>(Arenia)</i>		
DUE TO  <b>442X</b>									
DUE TO  <b>442X</b>									
DUE TO  <b>442X</b>									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		Month <b>Aug.</b>	Day <b>13</b>	Year <b>1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rural Paw Paw, W. Va.</b>	20f. (City or town) <b>Paw Paw</b>	(County) <b>W. Va.</b>	(State) <b>W. Va.</b>
21. I certify that I attended the deceased from <b>8-13-1958</b> to <b>8-19-1958</b> , that I last saw the deceased alive on <b>8-19-1958</b> , and that death occurred at <b>9:35 P.M.</b> from the causes and on the date stated above.							ADDRESS (Street, city or town, state) <b>Paw Paw, W. Va.</b>		
ACTUAL SIGNATURE <b>W. F. Williams</b>							DATE SIGNED <b>8-20-58</b>		
PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Aug. 23, 58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>W. Va. Cem.</b>		22d. LOCATION (City, town, or county) <b>Rural Paw Paw, W. Va.</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Parks Funeral Home, Berkeley Springs,</b>		ADDRESS <b>Berkeley W. Va.</b>		24a. REC'D BY REGISTRAR <b>AUG 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

1-800-618-1450 DENTRALIS STATE CHARTER

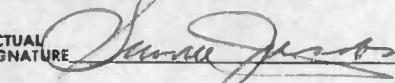
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8632

## CERTIFICATE OF DEATH

Reg. Dist. No.

08641

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>41 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ORPHEA</b>		First <b>C.</b>	Middle <b>SHIRER</b>
4. DATE OF DEATH <b>AUGUST 10 1958</b>		Month <b>AUGUST</b>	Day <b>10</b>
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>FEB. 4, 1895</b>		9. AGE (In years lost/birthday) <b>63 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. IF UNDER 24 HRS. Days <b>0</b>	13. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>JOEL MILLER</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA DIEHL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b> DUE TO <b>Auricular Fibrillation, Myocardial Fibrosis,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO <b>Myocardial Stenosis and Insufficiency</b> (c) <b>Aortic Stenosis and Insufficiency</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 24, 1946</b> , to <b>August 10, 1958</b> , that I last saw the deceased alive on <b>August 9, 1958</b> , and that death occurred at <b>1:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 Pershing Street</b> DATE SIGNED <b>8/11/58</b>			
ACTUAL SIGNATURE 			
PHYSICIAN'S NAME (Type) <b>DR. S. JACOBSON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8-10-58</b>		22b. DATE THEREOF <b>8-10-58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Addison Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Addison Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. B. Rutherford, Addison Pa</b>		24a. REC'D BY REGISTRAR DATE <b>8-12-58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Traub</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08642

8633

## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portion. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b>		b. COUNTY <b>HAMPSHIRE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT ASHBY</b>		d. STREET ADDRESS <b>BOX 24,</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>OSCAR</b>		First <b>M.</b>	Middle <b>SISK</b>	Lost <b></b>	4. DATE OF DEATH <b>AUGUST 3 1958.</b>	Month <b>AUGUST</b>	Day <b>3</b>	Year <b>1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 8, 1903</b>	9. AGE (in years lost birthday) <b>55 yrs.</b>	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Grocery &amp; Gas Station</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>JAMES W. SISK</b>				14. MOTHER'S MAIDEN NAME <b>CARRIE TUCKER</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>236-36-1691</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address <b></b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH <b>10 da.</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Coronary Heart Disease 3 wk.								
DUE TO (c) Uremic poisoning 10 da.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) none						
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>July 30, 1958</b> , to <b>August 3, 1958</b> , that I last saw the deceased alive on <b>August 3, 1958</b> , and that death occurred at <b>3:35 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James P. Hallinan M.D.</i> PHYSICIAN'S NAME (Type) <b>DR. EARL R. PAUL</b>		ADDRESS (Street, city or town, state) <b>140 Bedford St.</b> DATE SIGNED <b>8-4-58</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-6-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Ashby Cem.</b>		22d. LOCATION (City, town, or county) <b>Fort Ashby W. Va.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albert J. Schaefer</b>		

MANHATTAN STATE PENITENTIARY - NEW YORK - EX-100

CERTIFICATE OF DEATH

DECEASED

AUGUST 17, 1911.

DEATH CERTIFICATE

YOUNG, JOHN

200

DECEASED

DEATH

YOUNG, JOHN

200

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08643

8634

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>27 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CRESAPTON</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>ALBERT</b>	Middle <b>R.</b>	Last <b>SMITH</b>	4. DATE OF DEATH Month <b>AUGUST</b>	Day <b>21</b>	Year <b>19 58</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>FEB. 10, 1889</b>	9. AGE (In years last birthday) <b>69</b>	yrs.		IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13. FATHER'S NAME <b>JAMES SMITH</b>		14. MOTHER'S MAIDEN NAME <b>SARAH JAY</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 16 2692</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the stomach</b> DUE TO <b>151X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9 mo.</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Abdominal carcinomatosis</b>				6 mo.						
(c) DUE TO <b>Cachexia</b>				6 mo.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Severe anemia</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>140 Bedford Street</b>		(State)		
21. I certify that I attended the deceased from <b>July 24, 1958</b> , to <b>August 21, 1958</b> , that I last saw the deceased alive on <b>August 21, 1958</b> , and that death occurred at <b>2:25 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>M.D. 140 Bedford Street</b>					DATE SIGNED <b>8-21-58</b>	
ACTUAL SIGNATURE <i>James J. Hallinan M.D.</i>										
PHYSICIAN'S NAME (Type) <b>DR. JAMES HALLINAN</b>				Cumberland, Maryland.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 24, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fairview Christian Cem.</b>		22d. LOCATION (City, town, or county) <b>Artemus</b>		(State) <b>Pa.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Arthur S. Krause</b>		24b. REGISTRAR'S SIGNATURE				
				DATE <b>AUG 27 '58</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

67 BROWNSTEIN - HANNAH - GOLDBERG - HATZ CHAVIVAH

CERTIFICATE OF BIRTH

NAME:

NAME:

NAME:

NAME:

NAME:

NAME:

NAME:

NAME:

NAME:

NAME: JAMES J. RICE

NAME:

NAME: SARA GOLDSTEIN

NAME:

NAME: DAVID GOLDSTEIN

NAME:

NAME:

NAME:

NAME:

NAME: JAMES J. RICE

NAME: DAVID GOLDSTEIN

NAME: DAVID GOLDSTEIN

NAME: DAVID GOLDSTEIN

NAME: DAVID GOLDSTEIN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8635

## CERTIFICATE OF DEATH

Reg. Dist. No.

08644

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>17 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MC COOLE</b>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>LOY</b>	Middle <b>FRANKLIN</b>	Last <b>SMITH</b>
4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>17</b>	Year <b>1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 27, 1899</b>
		9. AGE (in years from last birthday) <b>59</b>	10. IF UNDER 1 YEAR Months <b>0</b>
		11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
12. Months <b>0</b>	13. Days <b>0</b>	14. Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W.VA. PULP &amp; PAPER MILL</b>	
11. BIRTHPLACE (State or foreign country) <b>ROCKINGHAM, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES SMITH</b>		14. MOTHER'S MAIDEN NAME <b>ANNA WHETZEL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>163X</b>		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic nephritis with terminal kidney 3 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</b>		(b) <b>Carcinoma left lung with metastases</b>	
DUE TO <b>Causes</b>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Congenital fracture 1st lumbar vertebra, approx. 1 year duration.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>3:35 A.M.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>30 July 1958</b> to <b>17 Aug 1958</b> , that I last saw the deceased alive on <b>17 Aug 1958</b> , and that death occurred at <b>3:35 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>122 S Centre St. Cumberland, Md.</b>	
ACTUAL SIGNATURE <b>Dr. Alfred Van Ormer</b>		DATE SIGNED <b>17 Aug. 58</b>	
PHYSICIAN'S NAME (Type) <b>DR. VAN ORMER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/19/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Philos</b>		22d. LOCATION (City, town, or county) <b>Westport, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boal</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 20 '58</b>	
ADDRESS <b>Westport, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper.  
The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08645

8636

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>		d. STREET ADDRESS <b>1 424 CENTRAL AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>SIMON Heilman</b>		First	Middle	Last	4. DATE OF DEATH <b>SNOWDEN</b>	Month	Day	Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b> <b>APRIL 26, 1874</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR <b>84</b>	IF UNDER 24 HRS. Months <b>84</b>	Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telephone Co</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIE</b>		12. CITIZEN OF WHAT COUNTRY <b>Shellsburg U. S. A.</b>		
13. FATHER'S NAME <b>CHARLES SNOWDEN</b>		14. MOTHER'S MAIDEN NAME <b>CORNELIA GIBNEY</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>212-03-6270</b>		17. INFORMANT		Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Coronary Embolism</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <b>Arterio Oclusive Cardio</b>				<b>Many</b>		
(c)		<b>Vascular Disease</b>				<b>years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cumberland</b>		(County) (State)
21. I certify that I attended the deceased from <b>8/20/58</b> to <b>8/22/58</b> , that I last saw the deceased alive on <b>8/22/58</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Cumberland, Maryland</b>		
ACTUAL SIGNATURE <b>W. F. Williams</b>		DR. W. F. WILLIAMS				DATE SIGNED <b>8/25/58</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/25/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>AUG 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the certificate and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87 JOURNAL OF LIBRARY AND INFORMATION SCIENCE EDUCATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08646

8637

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>7/31/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. STREET ADDRESS <b>605 N. Mechanic St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Laura</b>	Middle <b>M.</b>	Last <b>Stein</b>
4. DATE OF DEATH	Month <b>August</b>	Day <b>7</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/27/1870</b>
9. AGE (In years lost birthday) <b>88 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Martz</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Ennis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>592X</b>		16. SOCIAL SECURITY NO. <b>P.O. Box 599</b>	
		17. INFORMANT <b>Allegany County Infirmary Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> INTERVAL BETWEEN ONSET AND DEATH <b>592X</b> <b>&gt;</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Bercleral Arteriosclerosis</b> <b>&gt;</b>			
DUE TO (c) <b>Chronic Nephritis</b> <b>&gt;</b>			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senile deterioration</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/31/58</b> , 19, to <b>8/7/58</b> , 19, that I last saw the deceased alive on <b>8/7/58</b> , 19, and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. McLean</i>		ADDRESS (Street, city or town, state) <b>149 Greene St.</b> DATE SIGNED <b>8/8/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 11, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>S.S. Peter &amp; Paul Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Stein, Inc. Cumberland, Md.</i>		ADDRESS 24a. REC'D BY REGISTRAR DATE <b>AUG 11 '58</b>	
		24b. REGISTRAR'S SIGNATURE <i>Albert Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND - DEPARTMENT OF STATE - MARYLAND - MARYLAND

CERTIFICATE OF DEATH

88

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08647

8638

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>1 206 1/2 FULTON STREET</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>MARY</b>	Middle <b>ANN</b>	Last <b>STRAUB</b>	4. DATE OF DEATH <b>AUGUST 17 1958</b>	Month <b>AUGUST</b>	Day <b>17</b>	Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-3-73</b>	9. AGE (In years last birthday) yrs. <b>65</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>Adam P. Leonard</b>		14. MOTHER'S MAIDEN NAME <b>Emma Clear</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Magdalene Bibaum</b>		Address <b>Baltimore Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO <b>420.0</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Heterotrophic heart disease</b> ?									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>128 Union St</b>		20f. (City or town) <b>Cumberland</b>		(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Aug 17 1958</b> to <b>Aug 17 1958</b> , that I last saw the deceased alive on <b>Aug 17 1958</b> , and that death occurred at <b>128 Union St</b> , CUMBERLAND, MD, from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>George M Brown</b> ADDRESS (Street, city or town, state) <b>128 Union St</b> DATE SIGNED <b>8/18/58</b>									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, EXHAUL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/20/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St Mary's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumb. Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc - Cumb. Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08648

8639

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Sarah</b>	Middle <b>Summers</b>	Last <b>August</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	11. BIRTHPLACE (State or foreign country) <b>Ireland, Belfast</b>
13. FATHER'S NAME <b>John Douglas</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Mony</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Patient's chart.</b>
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident (Embolus)</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Left Bundle Branch Block Myocardial Fibrosis?</b>			
DUE TO (c) <b>Coronary Arteriosclerosis ?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
Bromidism, Uremia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 2, 1958</b> , to <b>August 9, 1958</b> , that I last saw the deceased alive on <b>August 8, 1958</b> , and that death occurred at <b>4:20</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel M. Jacobson</i>		ADDRESS (Street, city or town, state) <b>50 Pershing Street</b>	
PHYSICIAN'S NAME (Type) <b>Samuel M. Jacobson, M.D.</b>		DATE SIGNED <b>8/19/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 11, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Davis Memorial Cem.</b>	22d. LOCATION (City, town, or county), (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>AUG 12 1958</b>
			24b. REGISTRAR'S SIGNATURE <i>Arthur J. Hafer</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - LIFELINE  
CERTIFICATE OF DEATH



NAME OF DECEASED: **John Henry Hayes**

ADDRESS: **123 Main Street, Anytown, USA**

AGE: **65 years**

SEX: **Male**

RACE: **White**

RELIGION: **Christian**

EDUCATION: **High School Graduate**

EMPLOYMENT: **Retired**

CAUSE OF DEATH: **Heart Disease**

TIME OF DEATH: **10:00 AM, March 12, 2023**

PLACE OF DEATH: **Hospital Room 302**

DOCTOR IN CHARGE: **Dr. Michael J. Smith**

NOTICE: **This certificate is issued under the authority of the State of Anytown.**

RECORDED: **March 12, 2023**

SIGNED: **John Henry Hayes**

PRINTED NAME: **John Henry Hayes**

ADDRESS: **123 Main Street, Anytown, USA**

AGE: **65 years**

SEX: **Male**

RACE: **White**

RELIGION: **Christian**

EDUCATION: **High School Graduate**

EMPLOYMENT: **Retired**

CAUSE OF DEATH: **Heart Disease**

TIME OF DEATH: **10:00 AM, March 12, 2023**

PLACE OF DEATH: **Hospital Room 302**

DOCTOR IN CHARGE: **Dr. Michael J. Smith**

NOTICE: **This certificate is issued under the authority of the State of Anytown.**

RECORDED: **March 12, 2023**

SIGNED: **John Henry Hayes**

PRINTED NAME: **John Henry Hayes**

ADDRESS: **123 Main Street, Anytown, USA**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08649

8640

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA VALE</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK AND MEMORIAL HOSPITAL - MEMORIAL AVE.</b>				d. STREET ADDRESS <b>64 LA VALE COURT</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MABEL</b>		First	Middle	Last	4. DATE OF DEATH <b>TOMS</b>	Month <b>AUGUST</b>	Day <b>15</b>	Year <b>1958</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>MAY 3, 1910</b>	9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Frostburg</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>WILLIAM DUGAN</b>		14. MOTHER'S MAIDEN NAME <b>MAE KEEDY</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MARYLAND</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Status Asthmaticus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchial Asthma</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOFSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>8 - 15 1958</b>	(County) <b>8 - 15 1958</b>	(State) <b>8 - 15 1958</b>	
21. I certify that I attended the deceased from <b>6 - 10, 1957</b> to <b>8 - 15 1958</b> that I last saw the deceased alive on <b>8 - 15, 1958</b> , and that death occurred at <b>10:23 P.M.</b> from the causes and on the date stated above.										
ACTUAL SIGNATURE <i>Ralph W. Ballin</i>		ADDRESS (Street, city or town, state) <b>62 Greene St., Cumberland, Md.</b>								
PHYSICIAN'S NAME (Type) <b>DR. RALPH BALLIN</b>		DATE SIGNED <b>8-16-58</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/17/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Restlawn Mem. Park</b>		22d. LOCATION (City, town, or county) <b>Allegany County, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hafer, Cumberland, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR <b>AUG 19 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8641

## CERTIFICATE OF DEATH

Reg. Dist. No.

08650

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>34 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>		d. STREET ADDRESS <b>FLINTSTONE</b> <b>Route 1,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>Route 1,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>JOHNNY</b>	Middle <b>WALTER</b>	Lost	4. DATE OF DEATH <b>AUGUST 26</b>	Month <b>Day</b>	Year <b>19 58</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>SEPT. 3, 1945</b>	9. AGE (In years lost birthday) <b>12 yrs.</b>	IF UNDER 1 YEAR Months <b>12</b>	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>P.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ARTHUR WALTER</b>				14. MOTHER'S MAIDEN NAME <b>ORPHA KEEFER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>PATIENTS CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Osteogenic Sarcoma with</b> DUE TO <b>196-9</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>metastasis - generalized</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-24</b> , 19 <b>58</b> , to <b>7-26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7-26</b> , 19 <b>58</b> , and that death occurred at <b>10:30 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>441 N. CENTRE ST., CUMBERLAND, ED.</b> DATE SIGNED <b>8-27-58</b>							
ACTUAL SIGNATURE <b>William P. James</b> M.D.							
PHYSICIAN'S NAME (Type) <b>WILLIAM P. JAMES, M.D.</b>		22d. LOCATION (City, town, or county) (State) <b>Near Chaneyville Pa</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 29 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. A. Right</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08651

DRS. HODGES-MOULD

8642 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 HRS. - 51 MIN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		d. STREET ADDRESS <b>FREDERICK ST. APT. 4-D BENJAMIN APTS.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>BABY</b>	Middle <b>BOY</b>	Last <b>WHEELER</b>	4. DATE OF DEATH	Month <b>AUGUST</b>	Day <b>5</b>	Year <b>1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 5 - 1958</b>	9. AGE (In years from birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months <b>4</b>	IF UNDER 24 HRS. Days <b>5</b>	Hours <b>51</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>ALFRED WHEELER</b>		14. MOTHER'S MAIDEN NAME <b>TAYLOR, BESSIE MAE</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>MEMORIAL HOSPITAL-MEMORIAL &amp; WARWICK AVES.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>'762.5</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO  (c) DUE TO  (d) DUE TO  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <b>6 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. 122 So. Centre St. Cumberland, Maryland</b>								
ACTUAL SIGNATURE <b>Roger Hodges</b> DATE SIGNED <b>5/8/58</b>								
PHYSICIAN'S NAME (Type) <b>DRS. HODGES-MOULD</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>8/15/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Memorial Hospital</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>DRS. HODGES-MOULD</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 8 1958</b>		24b. REGISTRAR'S SIGNATURE <b>John Smith</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, if desired. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

WISCONSIN STATE DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFICATE NO.
EDWARD J. KELLY	60	M	APRIL 19, 1950	10:00 A.M.	HEART DISEASE	1950-11150
ADDRESS OF DECEASED						
101 N. 10th Street, Milwaukee, Wisconsin						
NAME AND ADDRESS OF PHYSICIAN						
Dr. John J. Kelly, 101 N. 10th Street, Milwaukee, Wisconsin						
NAME AND ADDRESS OF FUNERAL DIRECTOR						
John J. Kelly, 101 N. 10th Street, Milwaukee, Wisconsin						
NAME AND ADDRESS OF PERSON REPORTING						
John J. Kelly, 101 N. 10th Street, Milwaukee, Wisconsin						
NAME AND ADDRESS OF PERSON ISSUING CERTIFICATE						
John J. Kelly, 101 N. 10th Street, Milwaukee, Wisconsin						
DATE ISSUED						
APRIL 19, 1950						
SPECIAL INSTRUCTIONS						
None						

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08652

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transtel permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
8643  
1. PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

50 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

02 Cumberland,

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Potomac River

d. STREET ADDRESS

26 Greene St.,

e. IS RESIDENCE  
ON A FARM?

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First  
HARRY

Middle  
JOHN

Last  
WHITE

4. DATE  
OF  
DEATH

Month  
August

Doy  
13,

Year  
19 58

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

April 26, 1884

9. AGE (In years  
last birthday)

74

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Night watchman

10b. KIND OF BUSINESS OR INDUSTRY

2nd Nat. Bank

11. BIRTHPLACE (State or foreign country)

Washington, Penna.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Homer White

14. MOTHER'S MAIDEN NAME

Angeline John

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
(If yes, give war or dates of service)

No,

16. SOCIAL SECURITY NO.

214-05-9027

17. INFORMANT

Mrs. Fannie White 26 Greene St.,  
Cumberland, Md.

Address

INTERVAL BETWEEN  
ONSET AND DEATH  
sudden

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Asphyxia

975X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause lost.

(b)

Drowning

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES

NO

2  
2  
MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour o. m.  
p. m.

20d. INJURY OCCURRED  
While at work  Not while at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE  
*B. Skitarelic*

EXAMINER'S  
NAME (Type)  
B. Skitarelic, M.D.

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

August 13, 1958

22a. BURIAL, CREMATION,  
REMOVAL (Specify)  
Burial

22b. DATE THEREOF  
8/16/58

22c. NAME OF CEMETERY OR CREMATORIUM

St. Luke's Cemetery

22d. LOCATION (City, town, or county)

(State)

Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS  
Charles L. George Cumberland, Md.

24a. REC'D BY REGISTRAR

AUG 18 '58

24b. REGISTRAR'S SIGNATURE

*Charles L. George*



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08653

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>39 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X MT. SAVAGE</b>			
d. NAME OF HOSPITAL (If not in hospital, give name of address or institution) <b>WARWICK AND MEMORIAL HOSPITAL - MEMORIAL AVE.</b>		d. STREET ADDRESS <b>/</b>		d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>ELIAS</b>	Middle <b>JAMES</b>	Last <b>WILLIAMS</b>	4. DATE OF DEATH <b>AUGUST 18 1958</b>	Month <b>AUGUST</b>	Day <b>18</b>	Year <b>1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 13, 1882</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED COAL MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSIAH WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>ELIAS, MARY</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-14-4058</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Coronary Arteriosclerosis Myocardial Fibrosis</b> DUE TO (c) <b>Pulmonary Emphysema with Fibrosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>39 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>002 X Possible Pulmonary Tuberculosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>July</b>	Doy <b>10</b>	Year <b>1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>50 Pershing St.</b>	(County) <b>Cumberland, Maryland</b>
21. I certify that I attended the deceased from <b>July 10, 1958</b> to <b>August 18, 1958</b> , that I last saw the deceased alive on <b>August 17, 1958</b> , and that death occurred at <b>6:40A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 Pershing St., Cumberland, Maryland</b>							
ACTUAL SIGNATURE <i>James Jacobson</i>	M.D.				DATE SIGNED <b>8/18/58</b>		
PHYSICIAN'S NAME (Type) <b>Dr. S. M. Jacobson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug. 21, 1958</b>	22b. DATE THEREOF <b>Memorial Park</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Frostburg, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey L. Zeigler Hyndman, Pa.</i>		ADDRESS <b>50 Pershing St., Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 22 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knobles</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached (use as the burial-transit permit. Then please remove carbon paper). Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE

HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 4 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8645

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>45 yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>407 Grand Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lloyd Albert Winters</b>		First <b>Lloyd</b>	Middle <b>Albert</b>
4. DATE OF DEATH <b>August 30 1958</b>		Last <b>Winters</b>	Month Day Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1884</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railway Express (clerk)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Preston County W.Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>Preston County W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John L. Winters</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. <b>714-10-2508</b>	
17. INFORMANT <b>Mae Winters</b>		Address <b>407 Grand Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 Min.</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic C V disease</b>			
DUE TO (b) <b>Arteriosclerotic C V disease</b>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DATE SIGNED <b>August 30, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-1-58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>North Glade Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>North Glade, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS Cumberland, Md.	
		24a. REC'D BY REGISTRAR DATE <b>SEP 3 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08655

8646

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>506 Rizer Ave.</b>		d. STREET ADDRESS <b>506 Rizer Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>KATARZYNA</b>		First	Middle	Lost	4. DATE OF DEATH <b>Aug. 24,</b>	Month	Day	Year <b>19 58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Seot. 27, 1883</b>	9. AGE (In years lost birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR <b>Months Days</b>	IF UNDER 24 HRS. <b>Hours Min.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Waysil Hnatyk</b>		14. MOTHER'S MAIDEN NAME <b>Marya Tichocka</b>				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>234 12 9741D</b>		17. INFORMANT <b>Edward Yacenich</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Cancerous Liver</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Stomach</b> DUE TO (c)		
						INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cumberland, Md.</b>	(County)	(State)	
21. I certify that I attended the deceased from <b>Aug. 23</b> , 19 <sup>58</sup> , to <b>Aug. 24</b> , 19 <sup>58</sup> , and that death occurred at <b>605</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>William R James</b> M.D. <b>441 N. Center St</b> DATE SIGNED <b>8-26-58</b>						
ACTUAL SIGNATURE <b>William R James</b>		PHYSICIAN'S NAME (Type) <b>William R James</b> CUMBERLAND, MD						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-27-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Lawn Cemetery</b>	22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR <b>AUG 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08656

## CERTIFICATE OF DEATH

Reg. Dist. No.

8647								
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>9 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>		d. STREET ADDRESS <b>46 BOONE ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MR. ERNEST</b>		First <b>W.</b>	Middle <b>YATES</b>	Last <b></b>	4. DATE OF DEATH <b>AUG. 27 1958</b>	Month <b>AUG.</b>	Day <b>27</b>	Year <b>1958</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/9 1877</b>	9. AGE (In years lost 1st birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Receptionist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Luray</b>		12. CITIZEN OF WHAT COUNTRY? <b>VIRGINIA Luray U.S.A.</b>		
13. FATHER'S NAME <b>WARFIELD YATES</b>		14. MOTHER'S MAIDEN NAME <b>ANNA FRISTOE</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-8578</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH <b>45 minutes</b>				
420! Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Coronary Sclerosis		5 yrs				
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma Prostate and renal Metastasis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>						
20c. TIME OF INJURY Month, Doy, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b>		(County) (State)
21. I certify that I attended the deceased from <b>7/7/58</b> , 19, to <b>8/27/58</b> , 19, that I last saw the deceased alive on <b>8/27/58</b> , 19, and that death occurred at <b>12:20PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Richard J. Williams M.D.</b>						ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>		DATE SIGNED <b>8/28/58</b>
PHYSICIAN'S NAME (Type) <b>DR. RICHARD J. WILLIAMS</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-30-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8648

## CERTIFICATE OF DEATH

Reg. Dist. No.

08657

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>6 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLERSLIE</b>		
d. NAME OF HOSPITAL (If not in hospital, give name of town or city) OR INSTITUTION <b>WARWICK AND MEMORIAL HOSPITAL - MEMORIAL AVE.</b>		d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <b>HATTIE</b>	Middle <b>V.</b>	Lost <b>ZEIGLER</b>	4. DATE OF DEATH <b>AUGUST 16 1958</b>	Month Day Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1880</b>	9. AGE (in years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>JACOB KIMBLE</b>		14. MOTHER'S MAIDEN NAME <b>Kimmel</b>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>162-16-58068</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b>		<i>Arteriosclerotic vascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <b>renal disease (uremia)</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO					
(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-10-1958</b> , to <b>8-16-1958</b> , that I last saw the deceased alive on <b>8-16-1958</b> , and that death occurred at <b>8:27 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>ADDRESS (Street, city or town, state) M.D. Cumberland</b>			
ACTUAL SIGNATURE <b>W. F. Williams</b>		DATE SIGNED <b>8-18-58</b>			
PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL Aug 19, 1958</b>		22b. DATE THEREOF <b>Aug 19, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>100 F Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Stopstown Pa</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey N. Zeigler Hyndman, Pa</b>		ADDRESS <b>Hyndman, Pa</b>		24a. REC'D BY REGISTRAR DATE AUG 22 '58	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7-8 Film 6233 9-5-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

08658

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>5 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>		X ELLERSLIE d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MR. OWEN</b>	Middle <b>ZEIGLER</b>	4. DATE OF DEATH Month <b>AUGUST</b> Day <b>27</b> Year <b>19 58</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>X3 XBX 3-7-83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BERLIN, PA.</b>
13. FATHER'S NAME <b>CHARLEY ZEIGLER</b>		14. MOTHER'S MAIDEN NAME <b>NANCY MOSTOLLAR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>688-16-5805</b>	17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Arteria arteriosclerosis cardiovascular disease. (Dementia)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-4-58</b> , to <b>8-27-58</b> , that I last saw the deceased alive on <b>8-26-58</b> , and that death occurred at <b>10:05 AM</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Dr. W.F. Williams M.D. Cumblerland Md 8-27-58</b>	
ACTUAL SIGNATURE <b>Dr. W.F. Williams</b>		DATE SIGNED <b>8-27-58</b>	
PHYSICIAN'S NAME (Type) <b>DR. W.F. WILLIAMS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-30-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Stayestown Cemetery</b>	22d. LOCATION (City, town, or county) <b>Stayestown, Pa</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Zeigler</b>		ADDRESS <b>Hopman Funeral Home</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 3 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH-BEZLWORCE 18

## CERTIFICATE OF DEATH

NAME

NAME